Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month February 15, 3:00 Nirmala Shashikant Desai 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard 6304 Burnt Mountain Path Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 24, 1 Birthplace (State or Foreign Country)
 India 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 ☐ M 2 💢 F Yrs. 62 616-76-6191 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6304 Burnt Mountain Path 21045 Canada 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give A Year or Dates: 1 Tes 2 No Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hiralal Parekh Sharda Parekh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shashikant Desai/Husband 6304 Burnt Mountain Path Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/18/06 Baltimore, MD 21. Signature of Licensee

Edward A. 2re 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Øregorchik Catonsville, MD 21228 23a. Part1. Enter the disease for com or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yeer appendix earner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2: ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work?

1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO57-936

1 🗌 Yes

2 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 15, 2006

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

rthen "naturel", or items 23a or 28a-f ehov Itte Medical Ezaminer musit by notified at

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filed within 72 hours after

al Hygiene.

permit. Pages I and 2 should be file Depertment of Health and Mental Hy, important: if item 27 is marked other eny injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Division of Vital Records.

Examiner Physician/Medical To Be Medical Certification:

hysician authorite burial-t use as jo page 2 should within 24 hours after death.

To the Funeral Director: A completely filled in by the ft

The law requires that the death certificate be executed or Attending Physician: Hospitel

Completed by

State

29b. Signature and title of certifie 31. Date filed (Month, Day, Year)

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) Heather D. Mannuel No

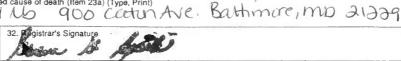
5 Pending investigation

6 Could not be

determined

FEB 1 6 2006

28a. Date of Injury (Month, Day Year)



Registrar

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1- State of Marylan		rtment of H tificate of L			ieņe 19. No. 0 0 6	04502
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) John DeCarlo, J. 4a. Facility Name (If not institution, give street and number)	r.	4b. City, Town, or	Location of Deat	2. Date of Death Month FEBRUAR	Day Year	06 8:05 AM
	Examir Funeral	ner	Saint Joseph Medical Cer 5. Social Security Number 6. Sex. 7. Age (In yrs.		If Under 1 Year	T O W S	8. Date of Birth	Ba.	ltimore rthplace (State or Foreign
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21215-0036	within	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	(Give k life. D	ent's Usual Occupa kind of work done of O NOT use retired,	luring most of wo	rking	Medicin	
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	/Medical Examiner		Due to (or as a conseq MULTIFLE	uence of):				CTURES	
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P.O. Box 687	The law requires thet the death certificats te hes been signed by the attending phy oage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□E	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
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	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Exeminer: On the basis of examina and manner stated.	wledge, death of the tion and/or investigation	occurred at the tim estigation, in my op	e, date and place inion, death occu	r, and due to the car irred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
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1	5+1		30. Name and address of person who completed cause of death (Item	1 23a) (Type, P		410	1.0	June 10	17006.
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiane. If item 27 is marked other than "natural", or iteme 23e or 28a-1 show or other treumatic event, If a Medical Eventing or and be notified at		20a. Method of Disposition	DAUGITER	20b. P	lace of Dispo	sition (Name	of	1	Date		Oc. Location -			. /
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×	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ncy						23d Dat	te of deliv	an/	
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	ne Ho ne Fu	Medical	(Check only 2 Medical 8 one)	xaminer: On the basis and manner:	of examinat	ion and/or in	vestigation, in	my opii	nion, death	occurred at the	ne time, dat	e and place,	and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	10.1	1		29c. L	icense	number		290	d. Date signed	d (Month,	Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10 02.46 AM EISGRAU CELIA tebosy 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bultimore Hospital 5 Bostinose N/A If Under 1 Year | If Under 24 Hrs. B Date of Birth Month Day, Year) DEC.14,1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 ₩ F 92 CZĘCHOSLOVAKIA 153-16-0964 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director N/A BALTIMORE 1 X Yes 2 □ No MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or itame 23a or 3419 GLEN AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: à 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 should be filed w h and Mental Hygier 7 is marked other th other traumatic svant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOTTMAN LOTTMAN FRUMET NAFTOLI 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 Department of Health a Important: if Itam 27 is any in ury or other trau 3419 GLEN AVENUE - BALTIMORE, MD 21215 ELIEZER EISGRAU / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🎇 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WELLWOOD CEMETERY 02/10/2006 PINELAWN, NY 21. Signalure of Funeral Service Vicensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. musor 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hardre. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Premon, a Sequentially list conditions, any landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) if or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performy 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred † Natural 5 Pending Injury 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO (oher Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 1 6 2006

8:40 P.M.	1215-0036
13, 2006	Maryland 21215-003(
FEBRUARY	Baltimore.
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Funeral	5. Social Security Numl	1 100	M 2□F	(In yrs. last birthday)	Months Days		8. Date of Birth (Month, Day		inthplace (State or Foreign Country)
Director	23-52- Usual Residence of De			<u> </u>			November	29,1940	170
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or 28	10e. Street and Number	r			10f. Zip Code		1	10g. Citizen of What	Country?
15-0036 In 72 hours after death with the Maryland 1 "natural", or items 23s or 28s-f show ledical Examinat must be notified at	2124 6	VILLOW	Spring 1	Kd., Apt. A		222		USA	
tem tem	11. Marital Status		2. Was Decedent E Armed Forces?		Was Decedent of It Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
hours after hours after or the Examine	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	kk
5-0036 72 hours aft matural, or dical Exami	15	. Decedent's Educ		16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	ss/Industry
21215-00 ed within 72 hor ygiene. ner than "neture it, the Medical I	(Specify and Elementary/Seconds	only highest grade	completed) College (1-4or 5+	(Give	kind of work done DO NOT use retire	during most of work ad)	king		
d 2121(filed within 7 Hygiene. The Man Truth	9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Su	DERINKA	idant	,	Dalhmon	e City
aryland 2121 Should be filed within and Mental Hygiene. Is marked other than sumatic event, tra Mg To Be Comp	17. Father's Name (Fin	st, Middle, Last)		•		18. Mother's Nam	e (First, Middle,	Maiden Sumame)	•
yla ould Menid arke atic	-105ei	sh tell	/			Blay	che W	YKNOWN	
Maryland nd 2 should be flittle and Mental Hy 27 is marked oth traumatic event	19a. Informant's Name	Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree	t and Number or Rui	rai Route Numbe	r, City or Town, State	
	Roy Fe	II JR.	, SON	20b. Place of Dispo	Ends le	eigh HV	Date Dal.	20c. Location - City	0(0) 2/220
Pages 1	20a. Method of Disposi	remation 3 Re	moval from State	cemetery, cre	matory or other pla		Date /		(
Baltimore, permit. Pages 1 a Department of Hes important; if itsm noy lojury or other page.	4 Donation 5			Dayvieu	2. Name and Addr		15/06	Baltin	
Baltimo	21. Signature of Funer	Cul Corse	> MO 45	5	Brille	y - ASKA	SDring	Ral Hom	e, P.A.
	23a. Part1. Enter the c	disease, or complications	ations that caused to cause on each line	the death. Do not en	ter the mode of dy	ing, such as cardiac			Approximate Interval Between
Physician	Immediate Cause (Fin			EAL CANCE	R				Onset and Death
/Medical	resulting in death)	C a.		consequence of):					
Examiner	Sequentially list condit	ions. b.							
ine si sa	it any leading to imme cause. Enter Underlyi Cause (Disease or inju- that initiated events		Due to or as a	cons a uence of					
be executed be executed burial-transit all Examiner	that initiated events resulting in death) Las	c.	Due to (or as a	consequence of):					
			(
		d.							
Box (Bath certification of the control of the con	IF FEMALE: 23b. Was decedent pr	ennant 23	Sc. It yes, outcome o					23d. Date of	delivery
death death dror dror	in the past 12 mg	nths?	1 Live birth 2 4 Pregnant at t		⊒Ectopic pregnand ⊒ Other (s <i>pecify)</i> _	су 		Month	Day Year
P.O. Box 687 net the death certificate the up the eltending physician for use as the Physician/Medic	9 Unknown		9□ Unknown						
	Part II. Other significa	nt conditions con	Inbuting to death bu	t not resulting in the u	inderlying cause g	iven in Part I.	'		to the cause of death?
w require been si should t							1 🗆 Y	′es 2 □ No 3 □	Probably 4 X Unknown
Reco							24a. Was autop	sv prior	autopsy findings available to completion of cause of
II Record The law requir tele hes been s page 2 should							perfor 1 ☐ Yes	rmed? death 2∭X No 1 □ Y	
Vital	25. Was case referred examiner?		onnitol:		10		th (Check only o	ne)	
Of \Physical Physical China Control China Control China Control China Control China		.,		nt 2 ☐ ER/Outpatie	III JU DON			ience 6 COther (5	pecify) HOSPICE
ding ding After funer	1 K Natural	5 Pending investigation	28a. Oate of Injury (Month, Day	Year) Injury	W	ork? ☐Yes 2☐No	200. Oescribe i	low injury occurred	
Division of Vital Records, or Attending Physician: The law requires taller death. Director: Alberthis certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	2 Accident 3 Suicide	6 Could not be	28e. Place of Inju	ry - At home, farm, st			28f. Location (S	Street and Number of	Rural Route Number,
Div effect	4 Homicide	GOLOLIIII	building, etc	."(Specify)	,,		City or Tou	vn, State)	
Division C To the Hospital or Attending P within 24 hours eiter death to the Funeral birector. Aller completely filled in by the funeral Medical Certification;	29a. Certifier 17	Certifying Phys	er: On the basis of	examination and/or in	th occurred at the	time, date and place opinion, death occu	, and due to the rred at the time.	cause(s) and manner date and place, and	r as stated. due to the cause(s)
within 2 To the complet	one) 29b. Signature and title		and manner stat	ed.		nse number		29d. Date signed (M	
Z N S S	255. Signature and little	Ja Si Collinoi			250. 61091			2/1	
	20 Name and addr	od normani ti	malatad 4 *	ath (line 02c) C	Prior)	13725			1/00
	DR. TARIO			LANEY VAL		TIMONIUM,	MD 210	0.2	
State	24 D 1 17 1 18 1 18 1 18 1			r's Signature	LEI KU.	I LIVELUII,	FW Z10	73	
Registrar	FF	B 1 6 200	16 Barens	J 15 14	SAGE!				

Dhysisi	312	1. Decedent's Neme (First, Middle, La	ast)		Certificate o	. 20411	2. Date of D Month	Reg. No. eeth Day_	Year	Time of Death
Physici /Medic		Willie	L.	faust		1	Frbio	ey 13	3005	0945
Examir	er	4e. Facility Name (If not institution, git	ve street and numbe Lochern (nee		ael)	4b. City, Town, or	r Location of Dea altimore	th 4c. County	y of Deeth N/A	
Funeral Director		5. Social Security Number 6. 8		Age (In yrs. last birth		ar If Under 24 Hr	s. 8. Date of B	irth ey, Yeer) 9, 1936	9. Birthplece	(State or Foreign
Maryland a-f show	tor	Usual Residence of Decedent 10e. State 10b. County Maryland	N/A	10c. City, Town	or Location	Baltimore				nside City Limits □Yes 2 □ No
th with the 23a or 28 ast be not	al Director	10e. Street and Number 501 Dolphin Street-Apt	303		10f. Zip Code	21217		10g. Citizen of	Whet Country? U.S.A.	
be filed within 72 hours efter death with the Maryland ital Hygiene. d other than "netural", or tiems 23a or 28a-f show event, the Medical Excreteer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	3? ∑(No	13. Was Decedent of If Yes, specify Co		Specify Yes or N rto Rican, etc.)	o- 14. Rad Bla Specif	ce - American Ir ck, White, etc.	
vithin 72 ho ne. han "netui e Medical	Completed	15. Decedent's E (Specify only highest grants) (0-12)	ducation ade completed) College (1-40	16a. [Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	cupation ne during most of wo ired) truction Work			lusiness/Industr larkins Bui	
ould be filed v Mental Hygie arked other t atic event, th	Be	12 17. Father's Name (First, Middle, Last	e Faust		Const		ame (First, Middle	, Maiden Surnar Mamie Faus	,	
aund aund aund aund aung	은	19a. Informant's Name/Relationship (19b.	Mailing Address (Stre	et a <i>nd Nu</i> m <i>ber or F</i> Pine Drive At	Rural Route Numi	ber, City or Town	, State, Zip Coo	le)
beges 1 and ent of Health It: If item 27 y or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specie			Disposition (Name of cremetory or other p	nlace)	Date 02/18/06	20c. Location	- City or Town,	
permit. Peges 1 Depertment of I Important: If ite any injury or ot once.	1	21. Signature of Funeral Service Lice		O KOP D	22. Name and Add					ar y lar ra
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. (Dono line.					Apr Inte Ons	roximate rvel Between set and Death
/Medical Examiner	<u></u>	Immediate Cause (Final disease or condition resulting in death)	a	Due to (or as a co	onsequence of):				7	29vs
rificate be executed og physician and as the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as a co	nisequerice ol).					
ertificate be ding physicis se as the bu	/Medicai	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or as a co	nsequence of):			-		
Ine law requires that the death cer ete hes been signed by the attendin page 2 should be deteched for use	Physician/	Part II. Other significant conditions of	contributing to death			given in Part I.		tobacco use co		
The law requires that the site hes been signed by the page 2 should be deteched.	۵		Į (mg ca	ncer		24a. Was	s an autopsy ormed?	availab	utopsy findings e prior to
The law restered by page 2 st	Completed						10	Yes 2 No	of death	tion of cause 1? s 2□No
Physicien: The this certificete	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		tient 2 ER/Outp	atient SLI DOA	Other: 4 2 Nursing		idence 6 □Oth		
r Attending Physi ter death. rector: After this c by the funeral dire	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b			ury W	☐ Yes 2 ☐ No		how injury occur		de Alexandra
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	al Certif	4 Homicide determined	building, e		n, street, factory, offic		City or To	(Street and Numb		
the Hos	edical	(Check only 2 Medical Exar	niner: On the basis and manner s	of examination and/	or investigation, in my	opinion, death occ	e, and due to the urred at the time	, date and place,	ariner as stated and due to the	cause(s)
To t Com	Σ	29b. Signature and title of certifier		~	29c. Lice	73757	Z	29d. Date signe	od (Month, Day,	
3		30. Name and eddress of person who	dervise	52	ype, Print)	Reid	jestowy		51136	
Sta Registr 4H 16 Rev 6/95	ar	31. Date filed (Month, Day, Year)	32. Hegis	trar's Signature	frills	_				

			1 - For State Registrar		ryland / D		nt of H	lealth and	d Mental Hy	_) 6	045	07
			1. Decedent's Name (First, Middle, Last)			-,-	•		2. Date of De		.,	3. Time of	Death
	Physici			JACK	GORH	AM, JR			Month	Day Feb 11, 20	Year 106	9:45 P	M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. Cit	, Town, or	Location of De		4c. County		1	
		•	HABORSIDE I	HEALTHCAR	E HARTFO	RD		BA	LTIMORE				
	Funeral Director		240-40-7341	7. Age	(In yrs. last birth	nday) If Und Months	er 1 Year Days	If Under 24 H Hours N	lin. (Month, Da	th y, Year) 20, 1927	9. Birth Cou	place (State or intry) N.C.	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside Cit	ty Limits
	Mary	ō	MD				ВА	LTIMORE				1 ☐X∕es	2 🗆 No
	the 28a	Director	10e. Street and Number		-	10f. 2	ip Code			10g. Citizen of	What Cou	intry?	
	3a or		1604 N. CAROLINE					21213			U.S		
	ms 2	Funeral	11. Marital Status	2. Was Decedent E	ver in U.S.	13. Was Dec	edent of H	ispanic Origin?	(Specify Yes or No Jerto Rican, etc.)	- 14. Rad	e - Amer	ican Indian,	
21215-0036	be tiled within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or items 23a or 28a-f ehow event, the Medical Examination to indiffer a	Ď	1 Never Married 2 Xtarried 3 Widowed 4 Divorced	Armed Forces? 1 □ ¥es 2 □ No 11 Yes, Give Year or Dates:	0		ecify Cuba 2□ X io	sn, Mexican, Pu Specify:	uerto Rican, etc.)	Specif	ck, White y:	, etc. Black	
o O	72 ho	ted	15. Decedent's Educ		16a. I	Decedent's Us	ual Occup	ation	addin a	16b. Kind of B	usiness/Ir	ndustry	
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	or th	5	8			M	ACHIN	E OPERA	TOR	UKn			
Maryland	uld be fits Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last) JACK G	ORHAM				18. Mother's i	Name (First, Middle, EN	Maiden Sumar MMA LEAC	•		
	s 1 and 2 should f Health and Mer ftem 27 te marke other treumatic		19a. Informant's Name/Relationship (Type CORA GORHAM Wife	e, Print)	19b.				Rural Route Number			ip Code)	
Baltimore,	00		20a. Method of Disposition 1 Surial 2 Cremation 3 Re 4 Donation 8 Other (Specify)	moval from State		, crematory or	other plac	CEMERT	Date V 02/21/06	20c. Location			AND
Baltii	permit. Pag Depertment Important: i eny injury o		21. Signature of Funeral Struce License	Hen	INDALLE	22. Name	and Addre	ss of Facility	OPOLITAN C	HAPFI			
			23a Part1 Enter the disease or complic	ations that caused t	the death. Do no	1	1639 N	. BROAD	<i>N</i> AY BALTIM	ORE. MAR	YLANI	Approximate	Α
	Physician /Medical Examiner		23a, Part 1. Enter the disease, or complice shock, or hear failure. List only one Immediate Cause (Final disease or condition resulting in death)	erelo	consequence o	scula			dent			Interval Bety Onset and E	ween
8760, <	ate be executed hysicien and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence o								
.O. Box 68	it the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (,			ate of delik	,	Year
Records, P.	The law requires that the te hes been signed by this age 2 should be detache	þ	Part II. Other significant conditions conf	ributing to death but	t not resulting in	the underlying	cause giv	en in Part I.		obacco use con	tribute to	2.4	leath? Jnknown
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_		Completed							24a. Was autor perfo		prior to co	topsy findings completion of completion of c	ause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth		Death (Check only of				
ö	Phys this aldir	2	1 ☐ Yes 2 No	1 L Inpatien	t 2□ER/Out		JUA	4 UNUrsin	g Home 5 ☐ Resid			rify)	
ב	ding Ph h. After th funeral	<u>6</u>	1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury	28c. Injur Wor	k?	28d. Describe	how injury occur	rred		
Division	ten leat tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, far (Specify)	m, street, facto		Yes 2 □No	28f. Location (: City or Tou	Street and Num wn, State)	ber or Rui	ral Route Num	iber,
	To the Hoepital or At within 24 hours after o To the Funerel Direct completely filled in by		29a. Certifier X Certifying Physic (Check only and) 2 Medical Examin	ician: To the best of	f my knowledge,	death occurre	d at the tir	ne, date and pl	ace, and due to the	cause(s) and m	anner as	stated.	
	To the h within 24 To the F complete	Medical	J.1.0,	and manner stat	ed.								
)	To the within To the comple	2	29b. Signature and title of certifier	nper	aeu	1 2	9c. Licens	number 300	661	29d. Date signe Fe Dua	Month	5 Pay Year)	00
	4		30. Name and address of person who cor SIREESH TRIPURANEN	npleted cause of de I 5601 LOCH	eath (Item 23a) (RAVEN BI	Type, Print) _VD BALT	IMORE	E,MARYLA	ND. 21214				
	Sta Registr		31. Date filed (Month Pay Year) 6 2	006 32. Registra	r's Signature	Agreed							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 13, 2006 5:32 A M Mary E. Gosne 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Future Care Cherrywood Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F 86 Yrs. Director 213-18-0227 November 21,1919 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show in than "neturel", or items 23a or 28a-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Sherwood Avenue United States of America 21208 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Yo
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Defense Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Assembly Line Worker Bendix Co. Pages 1 and 2 should be filed a nent of Health and Mental Hygic int: If item 27 Is markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Knapp Elizabeth Sheets ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Brother) 121 She Iwo
20b. Place of Disposition (Name of cemetery, crematory or other place) 21208 Gordon Knapp 121 Sherwood Avenue, Pikesville, Maryland Date 20c. Location City or Tow 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St Michael Cemetery 02/16/06 Poplar Springs, MD 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signatule of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician livers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) inding physician ause as the burial-P.O. Box 68760. Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2 ☐ No 9□ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 🗆 No 1 Yes 2 No 1 TYAS Hospital or Attending Physicien: 24 hours after death. Funerel Diractor: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aurising Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital of within 24 hours at To the Funerel D 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person w of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

		For 1 = Stete Registrar	-	State o			Depa		t of H	lealth	and M	lental Hy)6	045	09
Dhurisi		1. Decedent's Name (First, Ma	iddle, La	ast)							-	2. Date of De	ath		- Year-		of Death
Physici /Medic		Eleanore Ga										Februa			2006	1:0	00 Р м
Examin	er	4a. Facility Name (If not institu	-		mber)					Location	of Death		4c. 0	Coun	nty of Death		
Europol		Johns Hopkin 5. Social Security Number	_	Sex	7. Age	(In yrs. last b	oirthday)	If Under			24 Hrs.	8. Date of Bir	th			lace (State	e or Foreian
Funeral Director		219-01-0435		1□ M 2√2 F		83	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 7/26/1	922°		Mar	yland	e or Foreign
p .		Usual Residence of Decedent				10c. City, To										0.1.1	Ohitimite
faryla show	ō	MD 10a. State 10b. Cou	N/	'A		Balt									1		City Limits es 2 ☐ No
the N 28e-f	rect	10e. Street and Number						10f. Zip	Code				10g. Citiz	en o	f What Cour	ntry?	
h with	by Funeral Director	3705 Ravenwe	ood	Avenue				1	2121	L3					S.A.		
ems 2	ner	11. Marital Status		12. Was Dec	edent E	ver in U.S.	13.	Was Deced	lent of H	ispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)	- 1		ace - Americ		
36 s after	y Fu	1 Never Married 2 X		1 ☐ Yes If Yes, Gir	ve ² ₩ N	0		1 ☐ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,			ity: Whi		
-00 hour	ed b	3 Widowed 4 Divor		Year or D	ates:	16	ia Dece	dent's Usua	I Occup	ation					Business/In		
215	plet	(Specify only his Elementary/Secondary (0-1	ghest gr	ade completed) College (1-40r 54	F)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d e retired	during mos	st of work	ing				,	
212 glene gerthe	Completed	8			1 401 01	·	Sale	s Cle	rk						tail		
ore, Maryland 21215-0036 is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene, insturel, or items 23e or 28e-f show other treumstic event, the Madical Example and instituted at	Be	17. Father's Name (First, Mide Unknown	de, Las	t)								e (First, Middle, (Unknow		Suma	ame)		
ryla hould d Mer marke	우	19a. Informant's Name/Relati	onshin	(Tyne Print)		10	ah Mailir	ng Address	(Street			al Route Numbe		Tow	m State Zir	Code	
Ma nd 2 s alth an 27 is r treu		Milton Gali			ban		370	5 Rav	enwo	ood A	venu	e Balti	more	, 1	Maryla	nd 2	1213
Baltimore, M permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tro once.		20a. Method of Disposition		75		20b. Place cemet	of Dispo	sition (Nan	ne of ther plac	(e)		Date			n - City or To		
Page Page Trent (1 ☐Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe			State	Ho1y	Ros	ary		,	2/18	/06	Bal	lt:	imore,	Mary	yland
Balt permit. Departr Imports any inji		21. Sign ture of Funeral Secv	ice Lice	nsee			22					ller-Di					
m goesa		23a. Part1. Inter the disease shock or heart failure.	(C)	THE	X							Baltimo		Mai	ryland	Approxim Interval B	
Box 68760, A sath certificate be executed attending physicien and for use as the burial-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. — Due to	(or as a	consequence	e of): e of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		OA I	26	ase					
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			oirth 2 nant at t	of pregnancy 2		Ectopic pro					23		Date of delive	ory Day	Year
S, P es that igned b		Part II. Other significant cond		1		11			ause give	en in Part	l.				ntribute to th		
Vital Records, sicien: The law requires the certificate has been signed irector, page 2 should be or	Completed	Conges	710	ence	u,T	teil	un	<u>. </u>				1	Yes 2∟	No	3 Prot	ably 4	_JUNKNOWN
Rec e law has b	mple											24a. Was		24b	. Were auto prior to co death?	psy finding npletion o	as available cause of
n: Th ficate or, pag		OF Management to man	line!									1 Yes	22 No			2 No	
of Vital Re hysicion: The la nis certificate had I director, page 2	To Be	25. Was case referred to med examiner? 1 Yes 2 No	licai	Hospital:	Innation	nt 2 ER/C	Outnation	nt 3□ DO	A Othe	00		h <i>(Check only c</i> me 5□ Resi			ther (Specif	w)	
g Phy gerthi		27. Manner of Death		28a. Date		/ 28b	. Time o		Bc. Injury Won			28d. Describe I				//	
endir eath. or: Af	atic	2 0 7 100 100 11	estigatio	on	,,			М		Yes 2	No						
Division of or attending Physatter death. Director: After this lin by the funeral d	Certification:	3 Suicide 6 Cos 4 Homicide det	ermined	286. Place	of Injui	ry - At home, . <i>(Specify)</i>	farm, str	eet, factory	, office			28f. Location (S City or Tox		Nun	nber or Rura	I Route N	umber,
ppitel cours a cors a core i	i Ce	29a. Certifier 1 Certi	fvina P	hysicien: To the	heet of	f my knowled	no dost	n conurad	at the tim	an data as	nd place	and due to the	221122(2)	and a	7.050.05.00.0	atod	
e Hos n 24 h e Fur	Medical	(Check only 2 Medi	cel Exe	miner: On the b and man	asis of e	examination a	and/or in	vestigation,	in my of	pinion, dea	ath occurr	red at the time,	date and p	place	e, and due to	the cause	ə(s)
To th withir To th comp	Me	29b. Signature and title of cer	tifier		Λ		01			e number					ned (Month,)
		manto	hole	m m D &	4#.	ending	Ph	ysicit	100	D	265	534		2	1151	06	
3		30. Name and address of pers		-		ath (Item 23a	(Type,	Print)	10	- D	(4.1	05 Por			m /	7.10	r V
Sta	te	31. Date filed (Month, Day, Ye		0 C M	Registra	r's Signature	2177	· / /		re ve	. (7 1	1 100	- 70N		(1,1,0	-120	
Registr		FFB 1 6 2	006	La Cont	,	r's Signature	and the										

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and N Certificate of Death		giene Reg. No. 0 0 6	04510
	Dharaia		Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physic /Medi		Richard Recse Hallowell	Feb	10 ZOOG	6:00 PM
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1323 Cabin Creek Hurlock Rd 1+Urlock		Dorche:	/
	Funeral Director		5. Social Security Number 3.15-20-423 124 M 2 T F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. Usual Residence of Decedent	8. Date of Birt (Month, Da Jan 14	y, Year) Co	hplace (State or Foreign untry) ryland
	anyland show	J.	10a. State 10b. County 10c. City, Town or Location Maryland Dorchester Hurlack			10d. Inside City Limits
	or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	ns 23a	eral	4323 Cabin Creek 1-turlock Road 21643 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No	,	of americal
900	ours after or Iter	by	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerlo 1 Yes, Site Yes, Site Yes, Site Yes, Site Yes or Dates:	Rican, etc.)	Black, White	e, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventral rules be political at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) iife. DO NOT use retired)	ing	automotiv	,
	should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manauman aumatic event, the Manauman aumatic event, the Manauman aumatic event, the Manauman auman auma	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	should be ind Mental s marked o umatic eve	2	Russell Warren Hallowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Plura	ZIIZADE	th layne	
	1 and 2 s Health ar tem 27 is		Jean Hallowell / Spouse 4323 Cabin Creek Hurlac			,
lore	0 0		1 Burial 2 Cramation 3 Demoval from State cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore,	permit. Pages Department of Important: If it any injury or c		*4 Donation 5 Other (Specify) Anctomy Giff Registry Feb ic 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Her			ryland
8	88 58		Maries Mario 510 Washington & (Cambrid	ge Maryland	
	Physician		23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	. ,	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Cerular Vascular Descriptions			642
	uted	Examiner	Sequentially list conditions, if any, leading to utinize date cause. Enter Underlying Cause (Disease or injury that initiated events c. Idu			1 1 2
8760,	cate be executed obysicien and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of):			/ -
9	tificate ig phy as the	0	0.			
О. Вох	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year
<u>α</u>	ires that signed b d be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed		24a. Was a autops perfor	an 24b. Were au	copsy findings available ompletion of cause of
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Check onl or		
of	Phys this ral di	To	1 Yes 2 10 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2		ence 6 Other (Spec	ify)
Division	Attending I r death. ector: After by the funer	Certification;	1 Avatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	od. Describe II	ow injury occurred	
Div	i git e	Certifi	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or At within 24 hours efter d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current of each occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and place, a current occurred at the time, date and the current occurred at the time, date and the current occurred at the cur	and due to the c ed at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
į		Σ	29b. Signature and title of certifier 29c. License number 126388		9d. Date signed (Month)	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Faddew MD 302 Colling	Hus	lock me	2006 L 21643
	Sta Registr		31. Date filed (Month, Day, Year) Separation of the property of the separation of t			
			FRI O (AND)			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			For State Registrer	State of N	1 arylar		artment rtificate				ental Hy	gien Reg. Ñ	UUU		145	2
	Dhusisi		1. Decedent's Name (First, Middle,	Last)							2. Date of De	Da	av Y	ear	3. Time of	Death
	Physici /Medio		Emerald J.Hub								Februa	ry 1	2, 20		1:20	a ^M
	Examir	ner	4a. Facility Name (If not institution, Mariner Health a			on	Glen	Bur	Location on ie	of Death			c. County of	runc		
	Funeral Director		218-22-5458	5. Sex 7. A 1 □ M 2√□ F	ige (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bii (Month, Di 5-7-19	rth a <i>y, Year</i> 20) 9 Ma	Birthp Coun ary	lace (State o. try) Land	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside Cit	ty Limits
	Maryi f sho	ō	MD Baltim	ore	Lan	sdowne									1 🗌 Yes	2∏No
	r 286	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wha	at Cour	itry?	
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-1 show to Medical Exar are trust be multibed at	al D	820 Seckel Ct.				2122	27				U.S	.A.			
	ems erre	by Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U	I.S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Spe	cify Yes or No	0-	14. Race - Black	Americ White,		
36	or It	y Fu	1 Never Married 2 Marrie	d 1 ⊡Yes 240 IfYes, Give	No.		1☐Yes 2		Specify:		, , , , , ,		Specify: \[
Ö	hours tural',	d b	3 🖾 Widowed 4 🗆 Divorced	Year or Dates	:	16a Daga	dent's Usua	I Coours	ation.			106				
15	in 72 in 72	ojet	15. Decedent's (Specify only highest	grade completed)		(Give	kind of wor DO NOT us	k done d e retired	during mos	t of worki	ng	100.1	Kind of Busir	1622/1116	austry	
21215-0036	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Waitr	ess					Foo	d Serv	vice		
b	a! Hyg	Bec	17. Father's Name (First, Middle, Li	•							(First, Middle					
<u>a</u>	Menta	To	James Emory Lowr	У					Char	lott	e Reed					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Madical Erap it act must be multilised at once.		19a. Informant's Name/Relationshi Gary Durham/Son	р (Турө, Print)			-				<i>Route Numb</i> Burnie			ate, Zip	Code)	
	1 and Healtl em 27 ther t		20a. Method of Disposition		20b. I	 Place of Dispo	sition (Nam	ie of			ate		ocation - Cit	tv or To	wn. State	
Baltimore,	ages int ot t: If it		1 ☐ Burial 2 X Cremation 3		_ (cemetery, crei st Arui	natory`or ot	her place						-	,	
ij	artme ortan injury		21 Signature of Funeran Service		V									1110		
Ba	permi Depa Impo any ir		Donne L	#Mindle	X	AI 2	nbrose 119 Ha	: Fui	neral nds F	'Home	e of La	ansd	owne owne N	ID 2	1227	
	LEGA		23a. Part1. Enter the dise e, or c shock, or heart failure. List o	omplication that cau	the dea	- ATT -									Approximate Interval Bety	een
	Physician		Immediate Cause (Final disease or condition	(PY	Thetan	Arto	111	Dis	lose					Onset and D)eath
-	/Medical		resulting in death)	Due to (or a	s a consec	quence of		J		,,,,				1	1-0	
	Examiner	L	Sequentially list conditions,	b										4.		
2.1/	per jisi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry	Due to (or a	s a consec	quence of):										
A	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consec	quence of):								-		
8760, K	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E		d												
9	tificat ig phy as th	ledi														
Вох	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	annancy				- 1	23d. Date of		-	,
-	the att	Physician/Me	in the past 12 months? 1 Yes 2 No	4□Pregnant 9□Unknown			Other (spe						Month	1	Day Y	ear/
P.0	that the ded by the detached	Phy	9 Unknown Part II. Other significant condition		but not son	leinn in the	مستناهما		a ia Dant I		220 Did	tobassa	uco contribu	uto to th	e cause of d	oath?
S,	ires tha signed the dei	i by		- 4	Cu -	Suiting in the d	nuenying ca	use give	ят игант					Prob		Inknown
Ö	w requir been si should	etec	Cheonic Obstru	2100 10	JACK	7	7-1-6									
Vital Records,	sicien: The law certiticate has t irector, page 2 s	Completed	- Mypertention								24a. Was auto		pric dea	or to con	psy findings a npletion of ca	luse of
<u>a</u>	ysicien: The is certiticate hadirector, page	မ င်	25. Was case referred to medical						OC Disco	of Dooth	1 Yes	2 N	0 1	Yes	2 No	
>		To B	examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatier	nt 3 🗆 DO	A Othe			(Check only ne 5 ☐ Resi		6 □Other	(Specifi	()	
of	문 를 필		27. Manner of Death	28a. Date of In (Month, L		28b. Time o		Bc. Injury Work			8d. Describe			(0,000)	,	
jo	Attendin death. ctor: Afi y the fur	atio	1 XNatural 5 Pending 2 Accident investiga	ition	ay rour,	, injury	М		res 2 🗆	No						
Division	l or Attendate death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Flace 01 1	njury - At h etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory,	, office		2	28f. Location (City or To	Street a	nd Number e)	or Rura	l Route Numi	ber,
۵	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		00- 0-48- Deta	Dissolution		- 1-2				- 1						
	To the Hospitel within 24 hours To the Funeral completely tilled	Medicai	29a. Certifier 1 To Certifying (Check only 2 Medical E.	Physicien: To the best xeminer: On the basis and manner	of examina	owledge, deat ation and/or in	n occurred a vestigation,	at the tim in my op	ie, date an pinion, dea	id place, a ith occurre	and due to the ad at the time,	cause(s date ar	s) and mann id place, and	er as st d due to	ated. the cause(s))
	o the o the omple	Med	29b. Signature and title of certifier	and manner			29c.	License	number	-		29d. Da	ate signed (/	Month,	Day, Year)	
	F 5 F ŏ			7 MD				D-6	+05	21		Feb	mory	13,	2006	
	2		30. Name and address of person w		death (Iter	n 23a) (Type,	Print) 3	25 f	10161	TAL	ORIVE	= 0	WTE	201	2	
	0		DR OCHANE								EM					
	Sta		31. Date filed (Month, Day, Year)		ar's Signa	ature	1	5								
	Registi	ali	property 4	C 2005		13	Sec. 25 4	1300								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registra Certificate of Death 2. Date of Death Day [3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2001 5:454M LL Esmar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE SECOURS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🔼 F 53 Director 436-78-6053 1953 Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at Yes 2 No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229-2017 USA 3720 EDMONDSON AVE. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) NURSE ASSISTANT HEALTH CARE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be BESSIE BARNES WILLIE HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 RUSLAND CT. FORT WASHINGTON, MD. 20744 19a. Informant's Name/Relationship (Type, Print) EDWARD HALL - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite eny injury or ot once. tX Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CEMETERY FEB.17,2006 BRENTWOOD, MARYLAND `4 Donation 5 Dother (Specify) 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG ROAD., BRENTWOOD, MD. 20722 21. Signature of Funeral S. vice Licens Librard Tromps 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EUMONIA Physician /Medical STRUCTIVE PULMONARY **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 2 No is after deam.

rel Director: After this cenus.

a by the funeral director, pr Fo the Hospitel or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0030355

Registrar

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State

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

BON SECOURS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month **Physician** 55 PM 02 2004 /Medical Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner manou N/A Baltimore Home If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. lest bilghday) 8. Date of Birth (Month, Day, Yaar) **Funeral** 119-10-8356 1□ M 20 F Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haalth end Mantal Hygiene. 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits XIX Yes 2 □ No Director MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 234 2095 Rockrose Avenue Be Completed by Funeral 21211 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XXo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married 5 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 KNo Spacify: Specify: white 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry parmit. Peges 1 and 2 should be filed within Dapartment of Haaith end Mantal Hygiene. Important: If Item 27 Is merked other than 'any Injury or other traumatic event, the Ma Elementery/Secondary (0-12) College (1-4or 5+) Directory Assistance Operator Telephone Company 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Vetter Nora Erlam 2 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Phyllis Perlman 1325 Roland Heights Avenue Daughter Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 2/17/2006 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) by Physician/Medical Examiner genrah the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) ettending physician end Division of Vital Records, P.O. Box 68760, Dementre Due to (or as a consequence of): Brown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Tes 2 19 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edicai Certification: To 1 Yes 2 1√0 eral Director: After this filled in by the funerel di 28b. Time of Injury 27. Menner of Death 28e. Date of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) within 24 hours aftar d To the Funeral Direct completely fillad in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) 2 WAS D 31464 Ser tow St Smite 300, Baltimore MD 21201 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 821 Nr. A. HASHMI (m) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician З:2⊘Рм 2006 FEBRUARY 12, James Marston Hall /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs Dec 15, 1933 Maryland Director 215-34-5721 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location worle Item 27 is marked other than "neturel", or iteme 23a or 28a-f eho: other traumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Towson Maryland| 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "neturel", or Iteme 23a or USA 21286 521 Goucher Blvd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ÄYes 2 □ No If Yes, Give Year or Dates: 1954-74 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Military/U.S. Gov. Elementary/Secondary (0-12) College (1-4or 5+) Retired Military Officer/Postal Service 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Ha11 Ruth Margaret Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 521 Goucher Blvd, Towson, Maryland Judith M. Hall/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. Catonsville, Maryland 2/15/06 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21 Signal In Funeral Service License
Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock friend fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in math) Physician CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HIGH CHOLESTEROL autopsy performed? res 2\(\tilde{\Delta}\) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 5 Pending To the Hospins.
within 24 hours after death.
To the Funerel Director: Aft 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-12-06 BEAUVOIS C . M D 62551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 7601, OSLER DRIVE, TOWSON, MARYLAND 21204 Afrest BEAUVOIS ERIC 31. Date filed (Month, Day, Year) FEB 1 6 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene 04516 Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Year 35/ Physician Oliver 02 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Baltimore Long Green Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Months Hours Yrs. 214-64-6909 11-23-1960 Virginia Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours after death with the Meryland Depertment of Heelih and Mentel Hyglene. Important: if tem 27 ie marked other than "natural", or hems 23a or 28e-f show any injury or other treumstic event, the Medical Examinar round be notified at each 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director Baltimore NA 10f. Zip Code 10g. Citizen of Whet Country? 10e Streef and Number 4904 Stafford Street Apt B 21229 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Service Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Odell Hart Pauline Cooke 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Alicia Hart/ Daughter 4904 Stafford Street Apt B. Balto, MD 21229 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ACremetion 3 ☐ Removel from State 02-22-06 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility amerla Jones Wylie Funeral Home 638 N. Gilmor St. Balto , MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Return Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Deficiency more Examiner Due to (or es a consequence of): Examine Donntia To the Hospital or Attending Physician: The lew requires that the death certificate be associted within 24 hours aftar death.

To the Funerel Director: Attar this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ostromylitis of 12164 Hip. Completed by 24b. Were eutopsy findings available prior to completion of cause ot deeth? 24a. Wes en eutopsy performed? 212 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 1 Naturel 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier (Check only one) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number MO 59056 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sc 600 WI west 32. Registrer's Signature 31. Date tiled (Month, Dey, Year) State Registrar

ORIGINAL

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Jemmie Hinton

Amend item#1, perMD, 933, 3/14/06 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mary Cecelia Havlik Month **Physician** 2-13-2006 4:00P M Mary Cecilia Havlik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 120 S. Meadow Drive | It Under 1 Year | It Under 24 Hrs. | 8. Date of Birth (Month, Day. Year) | North | N Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months IL 1 M 20XF 354-24-2377 Director 86 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No Anne Arundel Glen Burnie Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21060 120 S. Meadow Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Healthcare Nurse other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Pages 1 and 2 should be Louise Miller ပ Bartol Cesarec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any njury or other trau 120 S. Meadow Drive; Glen Burnie, MD 21060 Mr. John Havlik / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Arlington Nat'l Cem. 4-11-2006 Ft. Myer, VA 4 Donation 22. Name and Address of Facility Singleton Funeral Home, 21. Signat re of Fweral Sovice Licensee 1 Second Ave SW; Glen Burnie, MD 21061 mo1120 234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years par **Physician** Conge disease or condition resulting in death) /Medical Due to lo Examiner rars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnage 3 Ectopic pregnancy Day in the past 12 mon 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t lirector, page 2 s autopsy 1 Yes 2 No 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 sesidence 6 Other (Specify) Hospital: 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 11 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign and title of certifi-0 30. Name and address of perso vallo completed cause of death (Item 23a) (Type, Prin riedinger 8601 er

State

Registrar

31. Date filed (Month, Day, Year)

6 2006

April 1

32. Registrar's Signature

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of			giene 0 0	6 04519
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medio			James J.	Hickey			Februar		006 9:10 P M
	Examir		4a. Facility Name (If not institution, give s	street and number)		, , , , , , , , , , , , , , , , , , , ,	r Location of Deat	h	4c. County o	of Death
			Carriage Hil				Bethesda If Under 24 Hrs	D. Data of Diet		ontgomery
	Funeral		5. Social Security Number 6. Sex	7. Ago M 2□F	e (In yrs. last birthda Yrs.	/) If Under 1 Year Months Days	Hours Min.	(Month, Day	/, Year)	Birthplace (State or Foreign Country)
	Director		169-14-0854		85 Yrs.			December	21, 1920	Pennsylvania
	land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary 	to	Maryland Montg	omerv		Cl	nevy Chas	se		1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	011102)		10f. Zip Code			10g. Citizen of W	hat Country?
	h with		4 Hesket	h Street			20815		Uni	ted States
	items ?	Funeral		12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-		- American Indian, , White, etc.
9	after or its	正	1 Never Married 2 Married	1 X Yes 2 □ N	10	1 ☐ Yes 2X No	Specify:	to rindari, otor,	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at	d by	3 Vidowed 4 □ Divorced	Year or Dates:						White
5-	nati	Completed	15. Decedent's Edu (Specify only highest grade		(Gir	edent's Usual Occup re kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Bus	siness/Industry
12	withir ane than	g E	Elementary/Secondary (0-12)	College (1-4or 5	i+) ""		ollor		Δ11 t om/	otive Dealer
2	Hygie Hygie Ther int,		12 17. Father's Name (First, Middle, Last)		<u> </u>	Compt		me (First, Middle,		
an	d be	o Be		Francis	Higkov			Conovi	ieve Col	oman
Maryland	12 should be filed within n and Mental Hygiene. rie marked other than reumatic event, tha M	2	19a. Informant's Name/Relationship (Ty			iling Address (Street	and Number or R			
M	0 = 5 =		James J. Hickey	. Jr./ So	n 4	Hesketh S	Street Ch	evy Chas	se. Marv	land 20815
ā,	s 1 and 2 f Health item 27 other tre		20a. Method of Disposition		20h Place of Die	position /Alama of		Date		City or Town, State
٤	Page ento nt: ff ry or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	()† He;	ematory or other pla aven Cemet	erv I/	bruary , 2006	Silver S	pring, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licens	of A	M00335	22. Name and Addre ethesda-C ethesda, M	ess of Facility Ro hevy Cha aryland	bert A. 1 se Inc 20814-350	Pumphrey 7557 Wi 01	Funeral Home/ sconsin Avenue
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		tive Hear	r Failura				Doset and Death
	/Medical		resulting in death)		a consequence of):	Liraliule				
	Examiner		Sequentially list conditions,		ry Artery	Disease				
/	면 ##	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
V	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or as	a consequence of):					
8760,	be executed sicien and burial-transit			Due to (or as	a consequence or,					
87	5 × 5	dicai		d						
9 X	leath certifica ettending ph d for use as th	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date	of delivery
Вох	etter etter	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at		I □Ectopic pregnanc I □ Other (specify) _	у		Mon	,
0	that the d ed by the detached	hysi	9 Unknown	9□ Unknown						
σ,	The law requires that the ate has been signed by th bage 2 should be detache		Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause give	ven in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
rds	quire an sig uld b	ed b						1 🗆 1	∕es 2∭No	3 ☐ Probably 4 ☐ Unknown
ပ္သ	aw requir s been si 2 should	plet						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
of Vital Records,	The lav	Completed by						perfo	rmed? d	eath? □ Yes 2□ No
ita	ysician: The is certificate hadinector, page	Bec	25. Was case relerred to medical examiner?				26. Place of De	ath (Check only o	ne)	
>	Physician: this certific ral director,	2	1 Yes 2X No	fospital: 1 Inpatie		ent 3 DOA		Home 5 ☐ Resid		
	ding Ph th. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injur	Wo		28d. Describe h	now injury occurre	bed
Division	Attending r death. ector: After by the fune	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2 □No			
₹	- 0	E	4 Homicide determined	28e. Place of Ing building, et	ury - At home, larm, c. (Specify)	street, lactory, office		City or Tov		er or Rural Route Number,
	pital nurs a eral C		29a. Certifier 1 X Certifying Phy	nining. To the heat	of my knowledge, da	ath conversed at the ti	wa data and place	a and due to the	cause(s) and mar	nor as stated
	Hospital 24 hours a Funeral 6 letely filled	edicai								and due to the cause(s)
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	- S + Ö		\	XX			D0057124	,	Fahrer	ary 13, 2006
	OVI		30. Name and address of person who co	ompleted cause of c	leath (Item 23a) (Tvr	e, Print)	שטוונטטע	Т	reprus	11y 13, 2000
	IU"		Truong Bao, M.D.				e, Germa	ntown, M	aryland	20874
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature	4		-		
	Regist	rar		100000	and the second					

DHMH 17 Rev 1/2001

Registrar

6 2006

Months

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Baltimore

Days

JACKSON

10c. City, Town or Location

Bay View

7. Age (In yrs. last birthday)

and manner stated

The Johns Haphy, Hogyatal

32, Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 ☐ No

Maryland

2105 M

2. Date of Death

FEBRUARY

8. Date of Birth (Month, Day, Year)

Day

USA

10

Year

2000

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

Self-Employed

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

FUBRUARY

600 Nothwolf Street Baltimore MARKERING ZIZ87

Month

2 No

Day

24b. Were autopsy findings available prior to completion of cause of death?

10,2006

1 ☐ Yes 2 ☐ No

Year

Baltimore, MD

14. Race - American Indian.

Specify: African-American

Black, White, etc.

Month

Physician /Medical Examiner

1 - For State Registra

John's

10a. State

5. Social Security Number

212-60-3990 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

10b. County

Hop Kins

1 □ M 2X F

DALE

Funeral Director

r then "neturel", or items 23s or 28s-f show the Medical Exercinal must be notified at

To the Hospital or Attending I within 24 hours after death.
To the Funerel Director: After

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

Medical

29a Certifier

(Check only one)

29b. Signature and title of sertifier

BRIAN GARIBALDI

FEB 1 6 2006

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

		1 - For State Registrar			partment of Health ertificate of Deatl	h	Reg. No	ZIIIIh	04522
Physicia /Medic		Decedent's Name (First, Middle, La	Isaiah .	Jeffers	son		CINOTY	0 2006	3. Time of Death
Examin			ion Memorial Hospita		4b. City, Town, or Location	Baltimo	ore		N/A
Funeral Director			Sex 7. Age (In yrs	61 Yrs.	Months Days Hours	er 24 Hrs. 8. Min.	Date of Birth (Month, Day, Year, Jul 12, 19		place (State or Foreign intry) o. Carolina
Maryland febow	tor	10a. State 10b. County Maryland	N/A	city, Town or	Location Baltimo	ore			10d. fnside City Limits 1 ☐ Yes 2 ☐ No
with the 3a or 28a	il Director	10e. Street and Number 1729 East 35th Street			10f. Zip Code	1218	10g. Ci	itizen of What Cou	•
be filed within 72 hours after death with the Maryland tal Hygiene. It has not seen than "natural", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 1	3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 Yes 2 Xlo Specif		/ Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:	
within 72 ho jiene. r than "natur ine Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)	ducation ade completed) College (1-4or 5+)	(Gi	cedent's U sual Occupation ve kind of work done during mo b. DO NOT use retired) Carpento	_	16b. k	Kind of Business/fi	em Steel
should be filed w nd Mental Hygier marked other ti umatic event, In	To Be C	17. Father's Name (First, Middle, Last Joseph) n Jefferson		18. Mot	ther's Name (F	irst, Middle, Maider Emma	n Sumame) Jefferson	
to, 1910 yield yield yield the stand Should the stand Mer tiem 27 is marked other traumatic	-	19a. Informant's Name/Relationship Rosa Jefferson	(Type, Print)	19b. Ma	illing Address (Street and Num 1729 East 35th Street				p Code)
00		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Control of	Trigiliotal holli State		position (Name of rematory or other place) awn Cemetery & Cha	Date	20c. L	ocation - City or T. Baltimo:	
permit. Pag Depertment Important: I any injury o		21. Signatula of Funeral/Service Light	ly ESTE	2	22. Name and Address of Fac Estep Brothe 1300 Eutaw F	rs Funeral	Service, P. A	\. 217	
Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the decore one cause on each line. a. Due to (or as a conse	Riee	enter the mode of dying, such a	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
flicate be executed g physician and as the buriat-transit	edicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Psonho Due to (or as a conse c. Due to (or as a conse d.	.77 /	Varices				
) = n = 1	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. if yes, outcome of preging the preging the state of	tal death	B Ectopic pregnancy Discrete (Specify)			23d. Date of delive Month	rery Day Year
	Ď	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause given in Par	tl.	23e. Did tobacco		the cause of death?
	Completed						24a. Was an autopsy performed? 1 Yes 2 No	prior to co	opsy findings available ompletion of cause of
ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 €	ER/Outpat	Othor		heck only one) 5 ☐ Residence	6 □Other (Speci	fy)
Hospital or Attending Physician: !4 hours elter death !2 toursel Director: Alter this certificately filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending investigation		28b. Time Injur	of 28c. Injury at Work? M 1 Yes 2		. Describe how inju	ury occurred	
ital or Attend its efter death ral Director: led in by the i		3 ☐ Suicide 6 ☐ Could not to determined		home, farm, ify)	street, factory, office	28f.	Location (Street as City or Town, State	nd Number or Rur e)	al Route Number,
To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Pi (Check only one) 2 ☐ Medicaf Exa	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, de nation and/or	ath occurred at the time, date a investigation, in my opinion, de	and place, and eath occurred a	due to the cause(s at the time, date an	s) and manner as and place, and due to	stated. to the cause(s)
To t To t	Σ	29b. Signature and title of pertifier	A IN		29c. License number		29d. Da	eb 10, 2	
11		30. Name and address of person who	completed cause of death (Ite	om 23a) (Typ		niversi?	Hospita	P Balt	21218 may MD
Sta Registr		31. Date filed (Month, Day, Year)	32. Hégistrar's Sigr	nature .	hole			,	

_			1- For Amend Item 23a per Dr., G852,027	artment of Health and M 16/06dhb tificate of Death	lental Hygi	ene 006	04523
	Physic /Medi		1. Decedent's Name (First, Middle, Last) John Krasnisky		2. Date of Death Month FEDTUAR	Day Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) MURY/AND GENERAL HOSPITAL	4b City, Town, or Location of Death BOLLIMORE C	Hy	4c. County of Death	
	Funeral Director		5. Social Security Number 198-18-9898 0. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Nov 6,	rear) Cour	olace (State or Foreign otry) usylvania
	death with the Maryland ms 23s or 28e-f show	_	10a. State 10b. County 10c. City, Town or Lo	cation		1	0d. Inside City Limits
	the Ma 28e-1 s	Director	MD Baltimore				1√Yes 2□No
	3s or	D	10e. Street and Number 1217 W. Fayette Street	10f. Zip Code	109	g. Citizen of What Cour	ntry?
2	ems 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21223 Vas Decedent of Hispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Americ	an Indian,
12 X	be tiled within 72 hours after death with the Marylan hal Hygiene. ad other then "natural", or Items 23s. or 28e-1 show event, the Medical Esacimer must be notified at	by	1X Never Married 2 Married 1 TYYes 2 No	Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, Specify: whi	
215-15-	within 72 lene.	Completed	(Give I	ent's Usual Occupation kind of work done during most of workii DO NOT use retired)	ng 16	5b. Kind of Business/Ind	dustry
32	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then other traumatic event, ITEM	Com	12 0 claim	s representative		cial secur	itv adm
and	2 should be filed and Mental Hygi Is marked other sumatic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			unk
- lyre	s 1 and 2 should f Health and Men item 27 is marke other traumatic	P P	Frank Krasnisky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rura	I Pouto Alumbos	Sibour Tour Chair 7's	0.11
N N	1 and 2 Health a tem 27 is			herry Lane Mantec			Code)
Baltimore	Page nent o nnt: If		20a. Method of Disposition 1			c. Location - City or To	wn, State
Balt	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee Ronald S. Wade, Director St. Ba	Name and Address of Facility ate Anatomy Board 1timore, MD 21201			treet
			23a. Part 1. Enter the disease, of complications that caused the death. Do not ente shock, of heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or			Approximate Interval Between
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Terminal Aspirat:	ion		Onset and Death
	Examiner		Sequentially list and lists and lists	art Parlure	•		
136	uted Insit	Examiner	f any, leading to immediate cause. Enter Underlying Due to or as a consequence of): Cause (Disease or injury Disease Or	Lepu Disinsi	2		
# # 9.	rificate be executed Ig physician and as the burial-transit	ai Exa	hat initiated events c. Due to (or as a consequence of):	Gay Discussion	and the second s		
£	tificate ng phys as the	ledicai	d				
Division of Vital Records, P.O. Box	Hospitel or Attending Physicien: The law requires that the death cert 4 hours after death. Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use	by Physician/M		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
rds, P	w requires that been signed b should be deta		art II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.		co use contribute to the	
eco	e law requ has been le 2 shoult	Completed			24a. Was an	24b. Were autops	sy findings available
al B	icien: The certificate h rector, page				autopsy performed 1 ☐ Yes 2 🗗	death?	pletion of cause of
× ×	/sicier s certif	To Be	5. Was case referred to medical examiner? Hospital: 1 Vignations 2 ER/Outpations	26. Place of Death			
п of	ding Physicien: The n. After this certificate ha funeral director, page		7. Manner of Death 28a. Date of Injury 28b. Time of	3L DOA 4 Nursing Homi	e 5 Residence	6 ☐Other (Specify)	
Siol	tendir Jeath. tor: Al the fu	catic	2 Accident investigation	M 1 Yes 2 No			
Divi	itel or Attending after death rel Director: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 28	f. Location (Street City or Town, St	t and Number or Rural I tate)	Route Number,
	he he	ledic	9a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of examination and/or investigation and manner stated.	ccurred at the time, date and place, an stigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stat and place, and due to the	ed. ne cause(s)
	To To con	≥ :	9b. Signature and title of centifier	29c. License number	29d. I	Date signed (Month, Da	ay, Year)
		3	D. Name and address of person who completed cause of death (Item 23a) Type, Pri	int) / 84536	1 11	9/3/06	
	Stat	,	Mark Komb / M Dx 40 Marke 1. Date filed (Month, Day, Year) 32, Registrar's Signature	fland Gienera	e HOS	rital	
15	Stat Registra	_	FEB 1 6 2006		,		

State of Maryland / Department of Health and Mental Hygiene 04524 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vaar Physician \mathbf{A}^{M} PAULINE B. Langlois February 11 2006 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Morningside House of Laurel Laurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M XXF Director 20, 1926 Massachusetts 79 031-18-0292 Usual Residence of Decedent with the Maryland ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marical Examinar must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Howard Laurel 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8841 Herons Flight 20723 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter anen of Health and Mental Hygione. anen If item 27 Is marked other than "naturat", or Ite ary or other traumatic event, the Moucal Estatura. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: δ Specify: White 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Brule ျှ Alice Poirier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhea Sabot/Daughter 8841 Herons Flight, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Othey (Specify) Lakemont Memorial 2/16/2006 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00160 313 Talbott Avenue, Laurel, MD can anuel Kans Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ear /Medical Due to (or as a consequence of) Examiner Securitially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 1 Tes 2 No ZXNo or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other 4 Nursing Home 5 Residence KNOther (Specify) Living Hospital: မှ 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1XXVatural death. 1 ☐ Yes 2 ☐ No 2 Accident lilled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after o 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Course D43237 February 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 14201 Laurel Park Drive, Laurel, MD 20707 Paul Armstrong 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 6 2006 Registrar

			State of Maryland / Dep				211116	01525		
			1- State RegistAmend Item #7 Per FH G852 2/1	elendare or r	Dealii	2. Date of Dea	Reg. No.UUU	3. Time of Death		
	Physicia	an	Decedent's Name (First, Middle, Last)			Month	Day Ye	ar		
	/Medic	al .	Dorothy E. LaFon	45 Gh T	d continue of D		1ary 6, 2006 11:45 P			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or			1			
			Eldercare Gardens 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		nthicur			e Arundel Birthplace (State or Foreign		
	Funeral Director		23i-18-5444 1 M 2 DXF 85 Yrs.	Months Days		Hrs. 8. Date of Birth Min. (Month, Day Dec. 26	1920 V	Country) 'irginia		
		ŀ	Usual Residence of Decedent			500. 20	, 1320 (1181114		
	yland Now		10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits		
	Mar.	to	MD Baltimore	Arbu	tus			1 ☐ Yes No		
	h the	lre	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	t Country?		
	th wit	aD	5000 Shelbourne Road	2	1227		United	States		
	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	J. Was Decedent of Hi	ispanic Origin In, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - / Black, V	American Indian, White, etc.		
9	or It	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No X If Yes, Give	37	Specify:		Specify:	White		
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Modical Exam for most to molified at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1-11-10-10-	- 11		16b, Kind of Busin	and finduction		
Γζ	"nat	lete	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupa ve kind of work done o . DO NOT use retired	ation during most of ii)	working	Montgomer	,		
12	within ane. then	m d	Elementary/Secondary (0-12) College (1-4or 5+)	Sales	,		Wards	•		
2	filed Hygir ther ont.	ŏ	17. Father's Name (First, Middle, Last)	Bares	18. Mother's	Name (First, Middle,	Maiden Sumame)			
Maryland	d be ental	To Be	Archie D. Hudson		Sa	allie				
<u> </u>	shoul nd Me mark	Ĕ	19a, Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street a		or Rural Route Numbe	r, City or Town, Sta	te, Zip Code)		
\leq	Ith ar 1th ar 27 le		Douglas LaFon Son 618	Woodsdale	e Road.	. Catonsvi	lle, MD 2	1228		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydjene. Department of Health and Mental Hydjene. Department of Health and Mental Hydjene. Branchent: If item 27 le marked other than "naturel; or Items 23e or 28e-1 ehow many injury or other treumetic event, the Modical Examene must be mailted at ODICe.		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other plac		Date	20c. Location - Cit			
JQ.	age ent of nt: If i		1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify)		1	-11-2006	Floyd, Vi	roinia		
Baltimore,	artm orter Injui					Ambrose Fu				
ã	Dep Imp		Continual Control			ing Rd., A				
			23a. Part1. Enter the disease, or complications that caused the death. Do not e					Approximate Interval Between		
	Proysician :		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	500000	Unecc	Van Are	don	Onset and Death		
	/Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	C /LE ISKUL	74500	VAR Ace	ruedt	10 days		
	Examiner		Cenehanua	SCHAR	LNS	olerosi	NOY	15 YEARS		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	-		0	/	/		
~	outed id ansit	Examiner	that initiated events	ed ATHE	PRESC	deposi	\$	20 YEARS		
, O	ite be executed ysician and se burial-transit	EX	resulting in death) Last Due to (or as a consequence of):							
8760,		cal	d							
Ö	ng ph as tl	Med	IF FEMALE:	 						
Вох	death certifics te attending phad for use as t	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy	,		23d. Date o Month	f delivery Day Year		
Э.	the at	sici	1 Yes 2 No 4 Pregnant at time of death	Other (specify)			No.	ouy ou		
P.O.	that the de ed by the detached	Phy	9 Unknown		an in Dart I	23o Did to	phagga use contribu	ite to the cause of death?		
	Se USO	þ	Part II. Other significant conditions contributing to death but not resulting in the	1 CARL	-	1 □ Y		□ Probably 4 □Unknown		
ecords,	w require been si should b	Completed	1 3 CHEMIC CHRONING OPH INC	CARL	it.					
ec	e law has b	nple	ARRYLLMIAS. TRIOR STROP	Ze. Mu	1111 -	24a. Was	an 24b. Wei prio rmed? dea	re autopsy findings available r to completion of cause of		
œ	Th ate pag	Co	INFARCT DEMENTIA				2 10 1	Yes 20 No		
Vital	yelcien: Th is certificate director, pag	Be	25. Was case referred to medical			Death (Check only o	ne)	ACCUSTON		
of	S 2	မှ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		4 🗀 IVUISII	ng Home 5 Resid	lence 6 other (Specify ASSISTED		
n (ing Afte une	lon	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time Injury	y Worl	yat k? Yes 2 ∐ No		low injury occurred	51 1000		
Sic	Attending ar death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		103 2 100		Street and Number o	or Rural Route Number,		
Division	in Little	Certification:	4 Homicide determined building, etc. (Specify)	street, ractory, onice		City or Tow				
_	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	ath occurred at the tin	ne date and r	place, and due to the	rause(s) and manne	er as stated		
	24 h/s Fun etely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.							
	To the within 2 To the complet	Me	Cook Circolous and Albert and Silver	29c. License	e number		29d. Date signed (A	Month, Day, Year)		
}	⊢ s ⊢ ō		My Ma ATTENDING	Die	5200	2 /	FEBRUAR	48,2006		
•	3		30. Name and address of person who completed sause of death (Item 23a) (Typ	e. Print) ~	,		V. 1			
	2		Do. N.M. MACHIRAN 720 - C MAIDE	FN Choice	LA.	CATONSUL	lle, MI	48,2006		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A. A. B.						
	Registr		FFB 1 6 2006							

	1	State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar State Registrar					
Physician /Medical Examiner	4	1. Decedent's Name (First, Middle, Last) John Lockett Jr. 4a. Facility Name (If not institution, give street and number) Milford Manor 2. Date of Death Month Day Year O2 13 2006 10:15p 4c. County of Death 4c. County of Death Milford Mill Baltimore					
Funeral Director	5	217-24-3193 Maryland Usual Residence of Decedent					
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Tamportant: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaritment must be notified at once. To Be Completed by Funeral Director	1 5	MD Baltimore n/a 108. Street and Number 109. Citizen of What Country? 34.27 Dayta Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Novement of Street Sive No. 1 No. 1 No. 1 Novement of Street Sive No. 1					
d 2 should be filled within 72 hours att th, and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Evern To Be Completed by F	1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Lohn Lockett Sr. The distribution real of aless 1947 - 50 (Give kind of work done during most of working life. DO NOT use retired) Management 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Love					
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic evegoce.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maraget Lockett/Wife 20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ Removal from State 1 □ Content (Specify) 21. Signature 1 Funeral Sepace Licensee? 22b. Place of Disposition (Name of cemetery, crematory or other place) Carrison Forest Vet. 2-21-06 Uwith & Mills, Mills, Mills, Name and Address of Facility Wylie F/H PA Of Balto.Co. 9200 Liberty RD., Randallstown, MD 21133					
eath certificate be executed The sample of	ioni rvalililoi	Icai Evallille	23a Párt 1. Enter fhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Ammediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
that the death certificated by the attending phasician/Media	1yalcıdırımıcı	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					
been sign should be	ipiered by ri	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown autopsy findings availability of completion of cause of death?					
ding Physician. h. After this certific	ממ	o Re	0 26	0	0	0	25. Was case referred to medical examiner?
	edicarcer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
within To the company	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)					
State Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Ricky Lyons Jr. 06 - 1000Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27 28a-f perMF,0852,2/22/06 TT State of Maryland, Department of Health and Mental Hygiene 0 06 AKG 04527 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 8, 2006 9:55 A M Ricky Lyons, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore University Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1□**x**4 2□ F Yrs. Director 214-92-5639 27 Maryland Usual Residence of Decedent Manyland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Show the Medical Examiner must be notified at 1 Nes 2 No Director N/A **Baltimore** Maryland 28a-f the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3001 Arunah Avenue 21215 U.S.A or Items 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★No Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) **Bond Distributing Company** Helper 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy, Important: if Itam 27 is marked oths any injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lynndora Johnson Ricky Lyons Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6013 Barstow Road Baltimore, Maryland 21206 Lynndora Johnson Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 02/17/06 Windsor Mill, Md. 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 0 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) **Physician** Multiple Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dire to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cete has been sig , page 2 should b 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ♥ Yes 2 □ No 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Management 2 ER/Outpatient 3 DOA , L 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Naturat 2 X Accident 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2√√No 2/6/2006 pedestrian struck by auto investigation 1:30 A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2700 Blk W. Franklin Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide St. Baltimore, MD street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) February 11, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PPK 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

		•	For Stete Registrar		of Marylan	d / Depa		of He	ealth a		ental Hyg	giene	06	04528
			1. Decedent's Name (First, Mide	dle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Geraldine Pa	aige	Linton						2-13-			4:15A ^M
	Examin		4a. Facility Name (If not institution	on, give street and nu	ım <i>ber)</i>		4b. City, To	wn, or l	Location of	Death			nty of Death	
			Joseph Richie				Balt If Under 1		re If Under 2	A Men			timor	e City
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 72	last birthday) Yrs.	Months D		Hours	Min.	8. Date of Birtl (Month, Day 7-7-19	h v. Year) 2.2	9. Birth Cou	place (State or Foreign intry)
	Director		216-28-0380 Usual Residence of Decedent		12		l				1-1-15.	J.J.	PL	υ
	yland		10a. State 10b. Count	ty	10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow must be notified at	cto	MD Anne	Arunde1	В	rook1y	n							1 ☐ Yes 2 🔀 No
	ith th	Funeral Director	10e. Street and Number				10f. Zip Co	ode				10g. Citizen		intry?
	ath w	la l	5902 Estate Co				2122			1-0 /0-		U.S.	A. Race - Amer	toon to die.
	er de	nue	11. Marital Status	Armed F	cedent Ever in U. forces? 2 🔯 No	.S. 13.	Was Deceden If Yes, specify	Cuban	panic Orig n, Mexican,	in? (Spe , Puerto	cify Yes or No- Rican, etc.)		Black, White	, etc.
36	hours after ural', or ite	by F	1 Never Married 2 Ma 3 ☑ Widowed 4 Divorce	If Vas G	iive		1 ☐ Yes 218	No	Specify:			Spe	city: Wh	ite
215-0036	72 hours after death with the Marylan "natural", or Iteme 23a or 28a-f show idical Examiner must be notified at	ted		ent's Education		16a. Dece	dent's Usual C	Occupa	tion			16b. Kind o	f Business/l	ndustry
215	hin 7	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work of DO NOT use	retired)	unng most	OF WORK	rig			
ですが	ed wil	8	12			Tech	nical						ingho	use
and	tal H)	Be	17. Father's Name (First, Middle								(First, Middle,	Maiden Sun	name)	
ナ皇	Men Men Marke Marke	ျာ	Steven L. Pai	0		405 44-10		244	Mae			Chart To	Ctato 7	in Codel
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relation		uchtor						Houte Numberthicum,			ip Code)
نة و	permit. Pages 1 and 2 should be filed within Inspertment of Health and Mental Hygiene Important: If Item 27 is marked other then any njury or other treumatic event, the Magnes.		Mrs. Doris M. 20a. Method of Disposition	KILZ / Ua			osition (Name matory or other				Date LITTCUM,		on - City or 1	Fown, State
$13 \mid 0 \mid L$	permit. Pages Dependent of Importent: If it any njury or o		Burial 2 Cremation 4 Donation 5 Other	3 Removal from	1 State		matory or othe Ldge Me		l l	10	2006			
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7 ■			23a. Part . Enter to disease, shock, or he in ailure. Li			h. Do not en	ter the mode of	of dying	, such as	cardiac o	or respiratory ar	rrest,		Approximate Interval Between
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9	/Medical		resulting in death)	aDue to	(or as a conseq	uence of):		1	1		- 1 =1	. 1	1011	11
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b	be #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to	o (or as a conseq	uence of):								
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×	eath certificate be executed attending physicien and for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		⊒Ectopic preg	nnanov.				23d.	Date of deli	,
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, vi	w requires that s been signed to should be deta	b	Part II. Other significant condi	itions contributing to	death but not res	ulting in the u	inderlying cau	ise give	n in Part I.					the cause of death?
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Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to media examiner?	Hospital:				Othe			h (Check only o			Hor Date
0	o is is	5	1 Yes 2 DNo	1	Inpatient 2 e of Injury	ER/Outpatie 28b. Time o		c. Injury Work	4 ∐ Nu		me 5 Resident			SIM YOU THOU
0) 6	th. : Afte	to	1 Natural 5 ☐ Pene 2 ☐ Accident inve	/440	onth, Day Year)	Injury	М		:? ∕es 2 🔲!	No				
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<u>ී</u> ත්	s afta si Dir ed in b	Certification:	4 Homicide	Buil	ding, etc. (<i>Specii</i>	(Y)					City of Tol	WII, SIAIB)		
	To the Hospital or Attending Physicial Section 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	cai		ying Physicien: To the										
	the H Jin 24 the F nplate	Medical	one)	and ma	inner stated.									
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	10		30 Name and rodress of person	on who completed ca	use or death (Iter	11,23a) (Type	D'W L	1)8	elle	8	+ Be	who	MI	721287
	Sta	ate	31. Date filed (Month, Day, Ye	ar) 32.	Registrar's Signa	ature	- 60		7		. , , , ,			
	Regist		FEB 1 6	2006	Lance A.	130	Will Park							

			1 - For State Registrar	State of	f Marylan		artment rtificate			and M		giene Reg. No.	0 (6 0	1458	29
	Dhunia		1. Decedent's Name (First, Mic	idle, Last)							2. Date of Dea	Day		Yeer	3. Time of	Death
	Physic /Medi				Wallad	ce Hen	ry Ma	lcolm	1		Februa	ary 1	3,	2006	6:25	РМ
	Exami		4a. Fecility Name (If not institut	100.5			4b. City, 7	Town, or L	or Location of Death 4c. Count							
			Laurel Regio				Lauı						inc	e Geo		
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under a	Min.	8. Date of Birt (Month, Da)	y, Year)			ace (State o	r Foreign
	Director		227-34-9441 Usual Residence of Decedent		75	113.					Apr. 11	., 19	30	Virg	inia	
	land m		10a. State 10b. Cour	ity	10c. Cit	y, Town or Lo	cation							10	d. Inside Ci	ly Limits
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	r 288	iec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of V	Vhat Count	ry?	
	h with	<u>E</u>	4205 Cedar Tr	ee Lane				2086	6				U	SA		
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9	after or Ite		1 ☐ Never Married 2 🔀 M.		2 No	i	1 🔲 Yes 2		Specify:	, r derto	ricari, etc.)		Specify	k, White, e Whi		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28s-1 show he Wedical Exam ar must be mailted at	Completed by	3 Widowed 4 Divorc	ed Year or Da			7111						эрвспу	AATIT		
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	od 2 is 27 is r trau		Devona Malcol	m/Wife		1					Burtons				0866	
5	r Healthean		20a. Method of Disposition			lace of Dispo	sition (Nam	e of	- 1		ate		· ·	City or Tov		
JO T	age ent of nt: If		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		State	emetery, crer hland	-		- 1	Feb '	16, 06	McDo	owe i	11. V	iraini	а
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Second	~ /	моо7	22 I	Name and	Address	of Facility Fune	ral	Home, P	.A.				
			23a. Part1. Enter the disease,	or complications that ca	aused the death								Lam		Approximate	3
	Physician /Medical		shock, or heart livilure. Li Immediate Cadse Unal disease or condition resulting in death)	a	Myocard		nfarct	ion							Interval Bett Onset and I	ween Death
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Вох	that the death certific ed by the attending pl detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 Fetal	death 3	Ectopic pre	gnancy			23d. Date o				-	'oar
0.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown										Month Day Year	
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Sic	death death ctor: / the	ical	3 Suicide 6 Coul		of Injury - At ho	me farm etc			15 2 1	-	28f. Location (S	Stroot and	Numhe	ar or Bural	Route Num	har
Division	after Direction by	ertii	4 Homicide dete	rmined 286. Flace buildir	ng, etc. (Specify	()	eet, lactory,	Office		1	City or Tow		14011101	or or ribrar	r loute realin	201
	spita ours nerel filled		29a. Certifier 1XXCertify	ring Physician: To the	hest of my know	wiedne death	occurred a	t the time	date and	d place a	and due to the o	'allee/s) a	nd mai	nnar as sta	ted	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only 2 Medic	al Examiner: On the ba and mann	isis of examinat	ion and/or in	estigation,	in my opin	nion, deat	h occurre	ed at the time, o	date and p	olace, a	ind due to	the cause(s))
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	0		► Milkin	Man T.	Nin	ala	1) LLO	529	35	•	Febr	war	M-14	+, 20	006
	3		30. Name and address of pensor	on who completed cause	e of death (Item	23a) (Type.	Print) a		200	5)	- ^			0	1	
			WJ-Ninale	L 344	Umil	Persiti	7 Bh	124	#-11	3,	Silver	Spur	no	Md	20	901
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, A.

			For State			d / Depa	artment of H	lealth ar	nd Mental Hyg	iene	_	04530	
			Registrar			Cei	tificate of	Death		ig. 140.	U		
	Physici	an	1. Decedent's Name (First, Middle, Last) MARYAWE MORRIS						2. Date of Deat Month	Day	Year	3. Time of Death	
	/Media		MYCLYNNE			1 7				0			
).	Examir	er	4a. Facility Name (If not institution, giv	e street and numbe	or)		4b. City, Town, o	r Location of	Death	4c. County of Death			
-X-	3.1	à.	Johns Hopkins Ba				Baltim						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 5. Og = 5.2 = 6.8.4.4 1 \(\text{Min.} \) 7. Age (In yrs. last birthday) Months Days Hours Min.							Year)	Com	place (State or Foreign ntry) nington, DC	
1200	Director		509-52-6844 Usual Residence of Decedent			113.			Dec. 22	1951	Wasi	illigion, be	
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	Mary	ō	MD Baltimo	re	074	vings N	ทำไไร					1 ☐ Yes XXNo	
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	within 72 hours after death with the Maryland ene. than 'neturel', or items 23a or 28e-f ehow ha Nacisal Examinar must be notified at	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13.	Was Decedent of H	lispanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)			can Indian,	
(0	rite	Ē	1 ☐ Never Married 2 Married	Armed Force	S? No	1			Puerto Hican, etc.)		k, White,		
93	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:		1 ☐ Yes 2 🛣 No	Specify:		Specify	· Whi	ite	
2-0	72 ho	Completed	15. Decedent's En (Specify only highest gra	fucation		16a. Dece	dent's Usual Occup	ation	of working	16b. Kind of Bu	ısiness/In	dustry	
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nd	A 0 E	Be	17. Father's Name (First, Middle, Last,						s Name (First, Middle, I	Maiden Suman	10)		
<u>yla</u>		P	Francis William	O'Brien				Elano	r Lambert				
Maryland 21215-0036	d 2 should th and Mer 7 le marke treumatic		19a. Informant's Name/Relationship (* * * * * * * * * * * * * * * * * * * *					or Rural Route Number				
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Baltimore,	permit. Pages 1 a Department of He Important: If item eny injury or othe	1 3	20a. Method of Disposition 1XX urial 2 Cremation 3	Removal from Sta		lace of Dispo semetery, crei	sition (Name of natory or other plac	сө)	Date	20c. Location -	City or T	own, State	
Ë	ment ment ant:		4 □Donation 5 □ Other (Specif			ion Cer			, , ,	Burton			
ä	epart epart poor y in		21. Signature of Funeral Service Licer						Donaldson				
ш	40 E 9 9		43 SER		M00770				enue, Laure		2070	/	
			23a. Part1. Enter the disease, or com shock, or heart lailure. Listonly	plications that caus one cause on each	ed the deat line.	h. Do not ent	er the mode of dyir	ng, such as ca	ardiac or respiratory arr	est.		Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition	а	Cere	bral	Anerys	m R	souther.			12 20015	
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq		/						
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	p ti	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (ora	as a consuq	ulence of):							
₹	and -tran	Examiner	that initiated events resulting in death) Last	C. Due to /or :	as a conseq	uance of							
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687	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the			_ d							-		
×	ding se as	Physician/Med	IF FEMALE:	23c. If yes, outcon	ne of oregna	ancv				22d Da	e ol deliv		
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۵.	that led by deta		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	oacco use cont	ribute to t	he cause of death?	
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ō	Phys	To	27. Manner of Death	28a. Date of Ir		ER/Outpatier 28b. Time o	" OLI DOA	4 🗀 14013	sing Home 5 Reside			<i>TY)</i>	
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Division	dea dea ctor y the	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of	Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (Si	reet and Numb	er or Rur	al Route Number,	
Ö	tei or Attending Pt s after death. al Director: After th ed in by the funeral	Certification:	4 Homicide	building,	etc. (Specif	(y)	, ·,		City or Town	n, State)			
	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Certifying Pt	ysician: To the be	st of my kno	wiedge, deat	h occurred at the tir	me, date and	place, and due to the c	ause(s) and ma	inner as s	stated.	
	# Ho 24 P Fu letely	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner	of examina	ition and/or in	vestigation, in my o	opinion, death	occurred at the time, d	ate and place,	and due t	o the cause(s)	
	To th withir To th compl	Me	29b. Signature and title of certifier				29c. Licens		1	9d. Date signe	d (Month,	Day, Year)	
			MAIN	_, M.D.	Residen	t physi	ción RE	5-00	00	FEBRUI	My,	9 2006	
	,2		30. Name and address of person who	completed cause o	f death (Iten	n 23a) (Type.	Print)						
	10		DANIEL M- SC	JBBA	600	North	a wolfe	sol 2	et Balti	more	nn	21287	
	Sta	ite	31. Date filed (Month Day, Year) FEB 1 6	32. Pro gi	strar's Signa	ature	P -						
1	Regist	ar	LERI 6	ZUUb	ario .	A A							

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	Physici		1. Decedent's Name (First, Middle, Li	Mar Mar	tin		2. Date of De Month	ath 3. Time	of Death		
	/Medic Examin Funeral		4a. Facility Name (If not institution, gi	N MANO	(In yrs. last birthday)	4b. City, Town, or Location of BALT: MCR	of Death	4c. County of Death N/A th 9. Birthplace (State			
	Director		219-28-3058	1□M 2⊠F	74 Yrs.	Months Days Hours	Min. (Month, Da				
	yland how		10a. State 10b. County		10c. City, Town or Lo	cation		10d. Inside			
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	3a or	i Dir	1111 Mosher Street			10f. Zip Code 2121	7	USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic event, If a Moulcal Extending to use the nullfied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Novorced	12. Was Decedent E- Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Original Yes, specify Cuban, Mexican Yes 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: AA			
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Maryland	should of Men marke matic	ဥ	Pedro 19a. Informant's Name/Relationship	Fonseca (Type, Print)	19b. Mailin	g Address (Street and Numbe		esa Fonseca ar, City or Town, State, Zip Code)			
	and 2 saith ar		Audrey Fonseca Sister	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		11 Mosher Street Ba					
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec	fy)		sition (Name of natory or other place)	Date 02/17/06	20c. Location · City or Town, State Baltimore, Md.			
Ball	Depart Depart Import any in		21. Signature of Funeral Service Lice	1, 95%	0	. Name and Address of Facility Estep Brothers F 1300 Eutaw Pla	,	P. A			
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Me	ne death. Do not ento	1300 Eutaw Place of the mode of dying, such as	cardiac or respiratory a	rrest, Approxim	etween		
8760, <	ficate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, and the second control of the second	c	consequence of):			S picture			
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<u>α</u>	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did t	obacco use contribute to the cause of Yes Ø⊋No 3☐ Probably 4☐			
Vital Records,		Completed					24a. Was autor perfo	prior to completion of death?	s available cause of		
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othan	of Death (Check only o				
1 of	ding Phys h. After this funeral di	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day		28c. Injury at Work?		dence 6 Other (Specify) now injury occurred			
sior	Attending I r death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	n	rear) injury	M 1 Yes 2 1	No				
Division	al or Att	Certification;	3 Suicide 6 Could not 4 Homicide determined		y · At home, farm, stre (Specify)	eet, factory, office	28f. Location (: City or Tox	Street and Number or Rural Route Nu vn, State)	mber,		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier to certifying P	cause(s) and manner as stated. date and place, and due to the cause	(s)						
65	To the within 2 To the complet	Me	29b. Signature and title of certifier	2		29c. License number	1	29d. Date signed (Month, Day, Year)			
	6	. 0	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, I	Print) print) print) print) print) E	NO DI	Roman 2122	7		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Régistrar	's Signature	il monde	100	- WO PRO []			
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	•	For State Registrar	State of Marylan			of Health and of Death	Mental Hy	/giene Reg. No.	06	045	32		
Physiciar /Medica	100	Decedent's Name (First, Middle, Last)	Mary N	AcCoy			2. Date of D Month	eath Day	Year	3. Time o	f Death		
Examine: Funeral	r	4a. Facility Name (If not institution, give street) 4a. Facility Name (If not institution, give street) 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Bal-	n, or Location of De 1 n ore ear If Under 24 H ays Hours M	rs. 8. Date of B			imore hplace (State ountry)	or Foreig		
Director	251-03-9943 94 Yrs. Usual Residence of Decedent						Sep 2	2, 1911	So. Carolina				
tal Hygiene. Id Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Medical Exertainer and the notified at Be Commission by Europeal Directors.	2	Marviand N/A	10c. Cit	ty, Town or Lo	cation	Baltimore		10d. Inside City 1					
r 28a-	Lect	10e. Street and Number			10f. Zip Co			10g. Citizen	of What Co	untry?			
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Department of Health and Mental Hygiene Interportant; or Itama 23a or 28a-f show Important; if Itam 27 is marked other than "natural; or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examination at Discontinuous Discontinuous To Be Commissed by Eurogal Discontinuous	Completed	15. Decedent's Educal (Specify only highest grade of	ion	(Give	dent's Usual C kind of work of DO NOT use	one during most of a	vorking	16b. Kind o	of Business/	Industry			
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nent of Health int: If itam 27 iry or other tr		Dorothy Williamson 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Rem		Place of Dispo cemetery, cren	sition (Name natory or othe	of r place)	Date	20c. Locati	Dc. Location - City or Town, State Baltimore, Md.				
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tificate has been soor, page 2 should	٠.	05 W					per 1 ☐ Yes	opsy formed? 2 46	prior to death?	topsy findings completion of a	availab cause of		
fter this cer ineral direct	0	1 165 2 100	pital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	Home 5 ☐ Res	hath Check only one Home 5 Residence 6 Other (Specify 28d. Describe how injury occurred							
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Madical Cartiffication.	Certifica	3 Surcide 6 Could not be	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, factory, o	fice	28f. Location City or To	on (Street and Number or Rural Route Number, r Town, State)					
within 24 hours after o To the Funeral Direct completely filled in by		29a. Certifier (Check only one)	ian: To the best of my kno : On the basis of examina and manner stated.	owledge, death	n occurred at vestigation, in	he time, date and pla my opinion, death or	ace, and due to the courred at the time	e cause(s) and , date and pla	l manner as ce, and due	stated. to the cause(s	s)		
To th comp	Ξ	29b. Signature and title of certifier				cense number		29d. Date si					
h	1	30. Name and address of person who come Notes when we have the	oleted cause of death (Iter	n 23a) (Tune	DG Print	5878998	Hernite	Flare	7 127	2006			
7		Robert Grenneit	~ 70 900	Conh-	Aunu	Balhon	se Mi	2122	5				
State Registrar	e Č	31. Date filed (Month, Day, Year) FFR 1 6 20	32. Registrar's Signa					-00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2,29d,pen/ID C852,2/28/06 IT Department of Health and Mental Hygiene]] [04533 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 11 Physician Janice K. Malmgren February 10, 2006 11:16 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F Yrs. 513-36-5509 66 1939 Missouri Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 No **Funeral Director** Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itama 23a 14234 Arbor Forrest Drive #102 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 ⊠ Widowed 4 □ Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant Law Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fit t Health and Mental H item 27 is marked oth William Poteet Elaine Earhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18021 Red Rocks Drive, Germantown, Maryland 20874 if itam 27 David W. Malmgren/Son other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to February 20 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Emblem Cemetery Elmhurst Illinois 4 ☐ Donation 5 ☐ Other (Specify) 2006 M01433 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Difficile **Physician** Jostridium /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Box 68760,< resulting in death) Last Due to (or as a consequence of): by Physician/Medicai 88 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Chpatient 2 ER/Outpatient 3 DOA this After this 28b. Time of Injury 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. i Director: d in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours a Actifying Physician: To the bast of my knowledge death contined at the time, date and close and due to the date e(e) and manner at stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of ce

31. Date filed (Month, Day Year)

FEB 1 titier

6 2006

30. Name and address of Prson who completed cause of death (Item 23a) (Type, Print) Holmes

DHMH 17 Rev 1/2001

11:16 Am

2/10/06

lalmanen Jante

model.

M.D.

32. Registrar's Signature

29c. License number

D 00 62653

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Ma	ryland /		rtment of l			Reg. No.	06	04535	
Physici	ian	1. Decedent's Name (First, Middle, La Rahman A.	Merritt					2. Date of D	Day V 10,2006	Year	3. Time of Death 5:18am M	
/Medi Examir		4a. Facility Name (If not institution, give Washington Adventise	e street and number)			4b. City, Town,	or Location of Deat	Location of Death			7	
Funeral Director		5. Social Security Number 6. S 152–64–5130		(In yrs. last b	oirthday)_ Yrs.	If Under 1 Year Months Days			rth ay, Year) 9,1973		nplace (State or Foreign intry) ark, NJ	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince C										
th with the 23a of 28a set be notifi	al Direc	10e. Street and Number 1508 Timber Ridge La	ne Apt.202			10f. Zip Code 2078	32	10g. Citizen of W.			untry?	
Deficiencies, Mail yiailly 4.1.2.20000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show spiritury or other treumatic event, the Medical Examinar must be notified at 2008.	by Funeral Director	11. Marital Status 1 Marital Status 1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 Yes 2 No If Yes, Give			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 🏿 No Specify:			No- 14. Race - American Black, White, etc. Specify: Black		
s within 72 ho liene. r than "natur Ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)	College (1-4or 5+)			during most of wo		16b. Kind of	Business/l		
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and 2 sho ealth and N m 27 Is ma		19a. Informant's Name/Relationship (Patricia Merritt / N		19			Address (Street and Number or Run South 7th Street New			m, State, Z	ip Code)	
Pages 1 arment of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 5 4 Donation 5 Other (Special		cemet	tery, crem.	ition (Name of atory or other pla Cemetery	ace) Feb			c. Location - City or Town, State Hillside, NJ		
Definit. Page Department of Important: If any injury or once.		21. Signature of Fulleral Service Lice	nsee		22.		ess of Facility L. Stevens t. Fort. Ave)		
Physician /Medical Examiner per price of price o	Ical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. a. Howard Figure Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	oths?								very Day Year	
w requires that the tent signed by should be detailed.	by	Part II. Other significent conditions Hepparin 19-B	ent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No									
VICAL DEC Ician: The law certificate has b ector, page 2 si	e Completed	25. Was case referred to medical					26 Place of Do	24a. Wa auto peri 1 Yes	opsy formed? 2 No	prior to c death? 1 Yes	topsy findings available completion of cause of 2 No	
ysicia ysicia is cert direct	To B	examiner?	Hospital:	nt 2 ER/0	Outpatient	3□ DOA O	ther: 4 Nursing		sidence 6 🗆 C	ther (Spec	cify)	
tending Physeath. tor: After this	Certification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day)	y Year) 28b	o. Time of Injury]Yes 2 No	TYIEND	how injury occ			
DIVI		4 Homicide determined	building, etc	. (Specify)	HOME			1508 Time	den Nicht (JA6, H	YATISUNGE (MO	
Host 24 hou Fune etely fil	edical		hysician: To the best o miner: On the basis of and manner stat	examination a								
To the within To the comple	Me	29b. Signature and title of certifier	1				15256		29d. Date sig	neid (Month	n, Day, Year)	
h		30. Name and address of person who	()	eath (Item 23a	a) (Type, F	Print)		0 20852	- [

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible to Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Maiden Stewart 11: 20AM Frances 13 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner montgomery Sligo Creek Nursing 5. Social Security Number 6. Sex 77 Takoma Park Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 4-23-1913 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 SF 219-16-4399 92 Yrs. Director Georgia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Itam 27 is marked other then "naturel", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Funeral Director MD montgemery Park Takoma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8109 Garland Avenue 20912 USA death Race - American Indian, Black, White, etc. or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) liled within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation

Admin 1 Sprag 1 Specuring most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College [1-4or 5+) 12 Education 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Itam 27 is marked of Annie Rogers Stewart Maiden 19b. Mailing Address (Street and Number or Rural Rould Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place)

20c. Location - City or Town, State each/Nephew Kilte 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Le Crematory 2-16-06 Betsville MD 22. Name and Address of Facility Ropp Funeral + Cremation erukes Chesapeake Crematory 21. Signalure of Funeral Service Licenses J. 933 Gist Avenue Silver Spring, mo 20910 mo1358 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** hours /Medical Due to (or as a consequence of): Examiner Alzheimer Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 20 No 1 ☐ Yes Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral [Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21900 2-14-06 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Ho 7610 Carroll Aver Takoma Park, MD 20912 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

16

2006

		Pleas	se Type or Prin					-		gible.	
		For State		-	•	artment of H			2 U	06	04537
		1 - State Registrar Amend ITe 1. Decedent's Name (First, Middle,		FH G	852 292	58/196-2H) cau i	2. Date of Dea	eg. No. th		3. Time of Death
Physicia		Frances H. Ohl						Month Februar	v 10.	2006	11:00 A ^M
/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death			unty of Deatl	
CAUTITI	`	Laurel Regiona	1 Hospital			Laurel			Pri	nce Ge	eorge's
Funeral			6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Co	hplace (State or Foreign untry)
Director		577-58-0564 Usual Residence of Decedent	10 M 2 Z	6	2 Yrs.			Feb. 10	,1944	Wasl	h., D.C.
land w	1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Mary I sh	tor	MD Prince	George's	Gre	enbelt						1⊈ Yes 2 No
h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?
23a c	aiD	l B Crescent Par	kway			2077	70		U.S.A		
r dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of Hi. If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White	
s afte	by F	1 Never Married 2 Marrie 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☑ No	Specify:		Sp	ecify: Whi	te
hour		15. Decedent'	s Education		16a. Dece	dent's Usual Occupa	ition		16b. Kind	of Business/	Industry
nin 72 in "ing Medik	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(+)	(Give	kind of work done of DO NOT use retired,	uring most of worl	ang			
d with	Completed	10		,	Admin.	Asst.					ealth Dept.
al Hy d oth	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother's Nam	e (First, Middle,	Maiden Sui	mame)	
ould Men Merke Marke	ဥ	George Dudan			T		Mary F				7-0-43
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "naturel", or flems 23a or 28a-1 show any injury or other traumatic event, I'm Medical Evantrar must be notitled at once.		19a. Informant's Name/Relationsh				ng Address <i>(Street a</i> l Market :			-		
1 and Healt em 2		David A. Ohler 20a. Method of Disposition	- Son	20b. F		sition (Name of matory or other place		Date Date		ion - City or	
ages int of t: If It		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp						20/06	D	1	MD
nit. P artme ortan injur.		21. Signature of Funeral Service L		FC.		oln Crem. 2. Name and Addres		20/06 : Linco		wood, н	MD
Ded Trans		Delivere 1	W. Cal	reli	W 34	401 Blade					722
2		23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that cause	he deat							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a Congest		neart f	Failure					Onset and Death 7 days
/Medical		resulting in death)	Due to (or as			arrare					
Examiner		Sequentially list conditions,	b. Ischemie	c Car	rdiomyc	opathy					
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								
be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. <u>Diabete:</u> Due to (or as								
s be e	a		d Chronic	rena	al fail	ure				:	
leath certificate t ettending physi-	Physician/Medic										
h cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy			23d	f. Date of del	,
deat he ett	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
that the de	Phy	9 Unknown Part II. Other significant condition	1	ut oot so	ulting in the u	ndoshina agusa ayu	o in Bod I	23e Didto	bacco use	contribute to	the cause of death?
ires the signer	by	Occlusive Arter				, ,	an in Fait i.		es 2X∏N		robably 4 Unknown
w require been si should I	etec	Occidsive Aitei	Tai Disease	WILL	i Gangi	Lene					
The law cate has t	Completed				·		-	24a. Was autop		prior to death?	utopsy findings available completion of cause of
ician: Th		OF Man and referred to medical						1 ☐ Yes	28 No	1 🗌 Yes	2 □ No
iding Physician: th. : Atter this certifica ; tuneral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatier	nt 3 DOA Othe	\r	th (Check only o ome 5 ☐ Resid		7Other (Sne	crifu)
g Phy er this eral d	-	27. Manner of Death	28a. Date of Inju	iry	28b. Time o			28d. Describe h			ony)
ttending death. tor: Aft the tun	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	9	y rear)	Injury		res 2 □ No				
r Atta er de recto by th	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place of In building, et	ury - At h c. (Speci	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		lumber or Ri	ural Route Number,
ral Di											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director: After this certificate has been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the	edicai		g Physicien: To the best Exeminer: On the basis of	f examina							
thin 2 thin 2 the omple	Med	29b. Signature and title of certifier	and manner st	atec.		29c. License	number		29d. Date s	igned (Mont	th, Day, Year)
F \$ F 8		> Nena	il au	BL	W.	D D00175	502		Feb.	13, 20	006
1		30. Name and address of person v	who completed cause of o	teath (Ite	m 23a) (Type,	Print)					
2		Rene L. Gelber	. MD 14201	Laure	el Parl	k Dr., La	rel, MD	20707			
Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Sign	ature						
Registr	ar	FEB 1 6 200	SU JANGERO		1						

		_	For State Registrar	State of I		epartment o	of Health and I of Death		iene 0 6	0	4538
		-;	Decedent's Name (First, Middle,	Last)		-		2. Date of Dea Month		Year	3. Time of Death
	Physici		aporge	Ostovi	+2			Februe		OL	8:40 A ^M
	/Medic		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Tov	vn, or Location of Deatl		4c. County o	f Death	
	. S		Johns Hopkins B				altimore Ci		N/A		
	Funeral			5. Sex 7. 1X□ M 2□ F	Age (In yrs. last bin	hday) If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.		Year)	Countr	
	Director		219- 01-2649 Usual Residence of Decedent		86	113.		March 1	7,1919	Mary	Tallu
	land ow		10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
	death with the Maryland ime 23e or 28s-1 show imet be nutitied at	tor	Maryland B	altimore			Dundalk	ζ			1 ☐ Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of WI	hat Counti	ry?
	ith wil		1920 Sunberry	Road			21222		United		
	or dea	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	- America , White, e	
	36 s after	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1XXYes 2 If Yes, Give Year or Date	⊔No es: WWII	1 ☐ Yes 2 ☐	KNo Specity:		Specify:	Wh	ite
	-00-		15. Decedent's	Education		Decedent's Usual O	ecupation		16b. Kind of Bus		
	71 TE 4	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give kind of work of life. DD NDT use r	lone during most of wo etired)	rking			
	212 d with	E O	12 Years	0055		Oraftsman			Engine		g
	nd nd had had had had had had had had had ha	Be (17. Father's Name (First, Middle, La				18. Mother's Na	me (First, Middle,			
	yla outd to Menit	P	Frank Ostovitz		i fo				se Osto		0.11
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23e or 28e-1 ehov early injury or other traumatic event, the Medical Examinational Lendillish at once.		19a. Informant's Name/Relationshi Mrs. Florence	p (Type, Print) W. Margaret (Ostovitz		treet and Number or Re cerry Road				21222
	e, land Health		20a, Method of Disposition		20b. Place of	Disposition (Name	of	Date	20c. Location - C		vn, State
	ages of of		1 ⊠Burial 2 ☐ Cremation			y, crematory or othe and Mem. T	Park Cem. 2	2/11/2006	Baltir	more.	Maryland
	Baltimore, permit. Pages 1 ar Department of Heal mportant: If item any injury or otherance.		21. Signature of Funeral Service Li		7		ddress of Facility ck Funeral				
_	Bai permi Depa Impo any ir		Ma-	C. (_	and		ck Funeral se Ave. Du				
Ş		<	23a. Part1. Enter the disease, or co	omplications that cau	ised the death. Do	not enter the mode o	f dying, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	•		infarction	^				2 hours
3	/Medical		resulting in death)		as a consequence		-				
Car	Examiner		Sequentially list conditions.	0	ernia						2 months
R	be is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence	of).					~
0	60, be executed ician and burial-transif	хап	that initiated events resulting in death) Last		maturi :	of):					2 mentus
C	8760, sate be executed physician and the burial-transit										
3	687 tiflicate g physias the	edic		d							
, ,	Box 68 eath certific attending pl	Z	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outco	ome of pregnancy	3 □Ectopic pregi	nanov		7	of deliver	•
10	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death	5 ☐ Other (speci			Mon	th I	Day Year
10	Records, P.O. Box 68 The law requires that the death certific tile has been signed by the attending plange 2 should be detached for use as in	Physician/Medical	9 Unknown				Company Company	22a Dida	hadan wan anatri	huta ta th	a source of death?
to	S, res th		Part II. Other significant condition	s contributing to dea	th but not resulting i	n the underlying caus	se given in Part I.			3 ☐ Proba	e cause of death?
3	Ord requi	eted	Coronary A	viery Di	Xu X						
*	Rec e taw has t	Completed by						24a. Was autop perfo	sy p	rior to con	psy findings available inpletion of cause of
	al F							1 ☐ Yes	2 No 1	Yes	20 No
	Division of Vital Records, if or Attending Physician: The taw requires that refer death. Director: After this certificate has been signed in by the funeral director, page 2 should be of a fin by the funeral director.	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2 ER/O	utpatient 3 DOA	Other	eath (Check only only only only only only only only		r (Specific	
	Of I Phy ar this eral d	n: To	27. Manner of Death	28a. Date of (Month)		Time of 28c	. Injury at		now injury occurre		/
	nding r: Afte	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investig		Day rear/	Injury M	Work? 1 □ Yes 2 □ No				
	ViSi	tiffe	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Place of building	of fnjury - At home, fa	arm, street, factory, o	office	28f. Location (5 City or Tox	Street and Number vn, State)	er or Rurai	Route Number.
	Diffel or ral Diffel in led in										
	Division of Vital Rec To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical E	xeminer: On the bas	sis of examination ar	e, death occurred at nd/or investigation, in	the time, date and plac i my opinion, death occ	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stand and due to	ated. the cause(s)
	thin 2 the of the	Med	one) 29b. Signature and title of certifier	and manne	er stated.	29c. L	icense number		29d. Date signed	(Month, I	Day, Year)
	1 3 5 8	1	> Collecte	114 no	1.		051185				
	((x)		30. Name and address of person v	who completed cause	of death (Item 23a)	(Type, Print)	- 31(0)	0 11	- TIT UGON	7 4	1
	(34)		Colleen Chartma	, Mis	5505 Itapk	ine Bay	Virw Cive	e, Balti	more, when	rylan	not 21224
	**************************************	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	A. A					,
	Regist	rar	FED 1 @ 2009	5600	10. 500	Carlo					

			State Registrer Amend Item 1219	of Maryland	C892,02/16/06	halth and M Death	ental Hygier	2006	04539
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) ADDLPh PF CF 4a. Facility Name (If not institution, give street and	FF CRI		or Location of Death	Feb 06	year Year 2006	3. Time of Death
	Examir Funeral Director	ier	Maryland Correcti 5. Social Security Number 148-30-2517 Usual Residence of Decedent	ona lus	stitute Ho	Wunder 24 Hrs.	8. Date of Birth (Month, Day, Yea	Washin	ace (State or Foreign
	72 hours after death with the Maryland natural; or liems 23a or 28a-f show dical Examanar must be notified at	Director	10a. State 10b. County MD Washington 10e. Street and Number		y, Town or Location gerstown 10f. Zip Code		10g. C	10 Ditizen of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☐ No try?
	within 72 hours after death with the Marylan inee." Than "natural", or Items 23a or 28a-f show the Medical Exament must be notified at	Funeral Di	Armed	ecedent Ever in U.S Forces? s 2X No	S. 13. Was Decedent of H	21746 dispanic Origin? (Spe an, Mexican, Puerto P	cify Yes or No- Rican, etc.)	USA 14. Race - America Black, White, 6	
0000-C	72 hours aft 'natural', or dical Exami	by	If Yes,	Give r Dates:	1 ☐ Yes 2 ☑ No 16a. Decedent's Usual Occup (Give kind of work done	pation during most of workir		Specify: whi	
Maryland 21215-0036	e filec Il Hyg othe	Be Completed		e (1-4or 5+)	life. DO NOT use retire salesperson		S e	1f employ	ed
Maryia	2 should and Men ie marke reumatic	Tof	Adolph Pferrele Jr 19a. Informant's Name/Relationship (Type, Print) Arthur Pferrele/uncle		19b. Mailing Address (Street 120 Little Yo	and Number or Rura		or Town, State, Zip	
ญ์	00-		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro '4 □ Donation 5 ☒ Other (Specify) in S	om State	lace of Disposition (Name of emetery, crematory or other plane	D		Location - City or To	
סקו	permit. Peg Depertment Important: I any injury o		21. Signature of Funeral Service Licensee Ronald S wade	irector	Baltimore,	MĎ 21201	L	altimore S	
	Physician /Medical Examiner			to (or as a consequ	tage Liv	er dus	ease		Approximate Interval Between Onset and Death
,0070	death certificate be executed e attending physician and of for use as the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	to (or as a consequence to (or a consequen	rabhs c	disea	se		
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i (sp.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to	o death but not resu	ulting in the underlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to th	10
		e Completed	Of Western stored to restrict				24a. Was an autopsy performed?	death?	osy findings available npletion of cause of
	ling Physici 1. After this ce luneral direc	ToB	27. Manner of Death 12 Natural 5 Pending 28a. Da	□ Inpatient 2 □ E te of Injury fo <i>nth, Day Yeer)</i>	28b. Time of 28c. Injury Wor	y at 2	ne 5 Residence 88d. Describe how in		Prison
DIVISION	or Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place but the but th	ace of Injury - At hou	ome, farm, street, factory, office	Yes 2 □ No	281. Location (Street City or Town, Sta	and Number or Rura. ate)	l Route Number,
	the Hospitel hin 24 hours a the Funeral i	edical	(Check only 2 Medical Examiner: On the	the best of my know e basis of examinat lanner stated.	wledge, death occurred at the til tion and/or investigation, in my o	ne, date and place, a ppinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as so and place, and due to	ateu. the cause(s)
	To t To t	N	29b. Signature and title of certifier	-mp	29c. Licens DO C	5753	7 07	Date signed (Month, I	Day, Year)
Bys	Sta Registr		30. Name and ress of person who completed comp	e 180. Registrar's Signat	61 Koxbing	, Rd., F	tagerste	own, MI	21741

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per doc 8852 2-16-06 vt

		Amend ite	State of M	doc g arylani			nt of Health a	ind Men	ntal Hyg	iene	0.6	01.51.0
		Registrar				Sertifica	te of Death			eg. No.	00	04740
Physic	cian	Decedent's Name (First, Middle, Last)		-					Date of Deat Month	Day	Year	3. Time of Death
/Med		Ora Lee Ponti		Lee	W.	Pontiu			b.	13	2006	11:30 AM
Exam	iner	4a. Facility Name (If not institution, give					, Town, or Location of	f Death			ounty of Death	
**************************************	- Aggille	300 Lord Byron La 5. Social Security Number 6. Sec		T-1	ant hirth		ckeysville er 1 Year If Under 2	24 Hrs o	Date of Birth		Baltimo	ore
Funera Directo		242-32-7431	M 25xF	79			Days Hours	Min.	(Month, Day,	Year)	G NI	place (State or Foreign intry) C
	<u>'</u>	Usual Residence of Decedent		-				IV	iay 17	1921	0 11	C
ylanc now		10a. State 10b. County		10c. City	, Town	or Location						10d. Inside City Limits
Mar.	ğ	MD Baltimore			Coc	keysvi	lle					1 ☐ Yes 💥 No
h the	lred	10e. Street and Number				10f. Z	ip Code		1	0g. Citize	n of What Cou	intry?
th with	- C	300 Lord Byron I	Lane, Ap	t. T-	-1		21030			ι	JSA	
5-0036 72 hours after death with the Maryland naturel; or Items 23a or 28e-f show alse Examine transities at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	S.	13. Was Dece	edent of Hispanic Orig	gin? (Specify	Yes or No-	14	Race - Amer	
after after		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X	No		1 🗆 Yes		, 1 00110 11100	11, 010.7		Black, White	
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within ene.	I d	Elementary/Secondary (0-12)	College (1-4or	5+)		life. DO NOT				0.	vn Hor	••
tnd 212. be filed within tal Hygiene. d other then		12 17. Father's Name (First, Middle, Last)	n/a		по	memake		r's Name /Fi	rst, Middle, A			ne .
yland build be f Mental H arked of	Be	Alvin Shaw Willia	ms						homps		imame)	
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C, N 1 and Health mm 27 ther tr		David Eugene Pon 20a. Method of Disposition	tius/Son	20h Pt		310 Oce	ean Gatewa	ay, Qı			tion - City or T	
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Baltimore, permit. Pages 1 ar Department of Hea Important: If Item eny Injury or other		21. Signatur Sof Fun Fra Service (lident	Terry .			Lemmo	on Funeral Padonia R	Home	e of D	ulan	ey Val	ley, Inc.
_ 00200		Bryan W. Cla				10 W.	Padonia R	Rd., T	imoniı	ım,	MD 210)93
		23a. Part1 Enter the disease, or complished, or heart failure. List only or	ne cause on each li	ine.	. Do no	or enter the mo	de of dying, such as o	cardiac or res	spiratory arre	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease of condition resulting in death)	m.	Jear	2, ~	J	in four to	C/				
/Medica Examine		resulting in death)	Due to (or as	a consequ	ence of):						
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od sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):						
and -tran	Examiner	that initiated events resulting in death) Last	Due to (or as	2 20022	anna al	\.						
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Box sath cerr attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Fetal	death	3 □Ectopic p				230	 Date of deliver Month 	very Day Year
O. I le de the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath	5 Other (s	pecify)				W.G.W.	Suy Four
that the de ted by the a		Part II. Other significant conditions con	atabuting to doath h	ut not rocu	Iting in t	the condentation	anna anna ia Dagi		220 Did tob			the cause of death?
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VISION Attending r death. ector: After	Certification:	2 Accident investigation				M	1 Yes 2 N	10				
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L saurs a									<u> </u>			
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	Check only 2 Medical Exemit	ner: On the basis o	f examinati	viedge, ion and/	death occurred or investigation	d at the time, date and n, in my opinion, death	d place, and a	due to the ca	use(s) an	d manner as a	stated. to the cause(s)
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To To	-	29b. Signature and title of certifier	2-	*		29	c. License number				signed (Month,	
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S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 1 6 20		ar s signati	ul e	Sante	,					

DHMH 17 Rev 1/2001

Registrar

2006

AEM 06-01067 Amend Unpend item#8, 23a, PII, 27, 28a-f, per/IF, 0853, 3/2/06 II State of Maryland / Department of Health and Mental Hygiene Myron Price 1 - For State Registra Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 11 2006 **Physician** Myron Lawrence Price 2:47 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Johns Hopkins - Bayview MC
5. Social Security Number 6. Sex 7. Age (In n/a 8. Date of Birth 1/1/1969 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Days Months Hours 35 217-78-9684 Yrs. MD Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fehov r then "neturel", or items 23a or 28a-f eho the Medical Examiner must be coulded at MD Baltimore 1XX es 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 Potomac Ave. 21231 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X XIO If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12thGandscaping <u>Landscaping</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental h 27 is marked or treumatic evi (unk.) Marlene Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Health ar Important: If item 27 is any injury or other treu Margaret Clarke 3915 Colloway Ave. Balto., MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXurial 2 Cremation 3 Removal from State ?Sacred Heart 2-16-06 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Darrell L. Hunter FS 21. Signature of Funeral Service Licenses 2007 Eastern Ave. Balto., MD 21231 uncer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Methadone intoxication complicated by narcotic and cocaine use /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine siclan end burial-transit certificate be executed Due to (or as a consequence of): Box 68760. ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown certificate hes been signed irector, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> Cardiomegaly 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ○ es 2 □ No Obesity 24a. Was an autopsy performed? Olvision of Vital 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) XIXXYes 2 No 28b. Time of Fnd 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☑ No investigation Fnd 2/11/06 i or Attend after death Director: / 2 Accident **≡idnight** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 158 N. Potomac St filled in by 4 - Homicide To the Hospital c within 24 hours af To the Funerel Di residence Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 11, 2006 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple

Registrar
DHMH 17 Rev 1/2001

State

111 Penn Street Baltimore, Maryland 21201

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6 2006

RIPPLEN

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 6 04543 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Year Pennington FEB. /Medical 1742 M 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL SALISBUT A WICOMICO 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) June 21,1934 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F Months Hours 211-26-6332 Days Director York County, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show r then "naturef", or iteme 23a or 28a-f eho The Madical Exercipar roust be notified at 10d. Inside City Limits MD Somerset Director Princess Anne 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10448 Blue Bird Drive 21853 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White <u>ک</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Cleaning 12 Custodia1 Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Waldon Vanhart Nora Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is eny injury or other treu QDCE. Kathy Billings / Daughter 40 Locomotive Lane Colora, MD 21917 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 18, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Seemoval from State Susquehanna Memorial Park 4 □Donation 5 □Other (Specify) York, PA 21. Signature of Paneral Service Licensee 8. C 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fmmediate Cause (Final disease or condition resulting in death) meningitis Onset and Death **Physician** Asepfic onta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): physicler Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death Month Day 5 ☐ Other (specify) page 2 should be deteched Division of Vital Records, P.O. 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Diabetes rellitos 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2500 To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No Certification: 27. Manner of Death After 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation Director: 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours e 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marginer stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030690 FES. 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 145 E. Carroll St. 501:550mg, MD, MART, N Janes

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

2006

James 06-011 crn	Earl Ro 141	obe	Unpend item#23a,27,perM	ype or Print in F 1,9853,3/21/06 State of Marylan	id / Depa	rtmer	It of H	leaith and i	III Copi e Mental F	es Are Tygien	Legible.	01.51.1.
_			1 - State Registrar		Cer	titicat	e of l	Death	2. Date of	Reg. No	,000	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) James Earl Ro	herts					Month		3, 2006	
	/Medic Examin		4a. Facility Name (If not institution, give sa			4b. City,	Town, or	Location of Death			. County of Dea	
10	22.71.21		1820 Spence Street,	, Apartment 4	10			more			N/A	
3	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2 F 59	/ast birthday)_ Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of (Month)	Birth Day, Year,	9. Bir	thplace (State or Foreign ountry) est Virginia
	Director		213-46-3492 Usual Residence of Decedent						0 0 11 1	· · ·	7 10 11	
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Iteme 23a or 28a-f ehow ont, the Madical Examiner must be notified at	Funeral Director	10a. State 10b. County MD N/A	10c. Cit	ty, Town or Loc			timore				10d. fnside City Limits 1 A Yes 2 □ No
	with the	2	10e. Street and Number 1820 Spence Street	Apt. 410		10f. Zij	Code	21230			itizen of What C ited St	
	death me 23	era	<u> </u>	2. Was Decedent Ever in U	.s. 13. <u>W</u>	Vas Dece	dent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or		14. Race - Am	erican Indian,
9036	ours after iral', or Ital	d by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔯 Divorced	Armed Forces? 1 XYes 2 No 19 If Yes, Give Year or Dates: 19	68-	Yes, spe		Specify:	to Hican, etc.		эреспу.	White
Maryland 21215-0036	e filed within 72 hours sl Hyglene i other than "natural" vent, the Madical Ex	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 1			ent's Usu kind of wo OO NOT i	ork done d ise retired	ation during most of woi d)	rking	16b. F	Constr	·
q 5	Hygid Other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Mic	ldle, Maide	n Sumame)	
/an	uld be Aentel rked ific ev	To B	Percy Roberts, Sr.					Ве	ssie S	ee1		
lan	2 sho and h is me	1	19a. Informant's Name/Relationship (Typ	oe, Print)	1	_		and Number or Ru		-		Zip Code)
9	1 and lealth im 27 ther tr		Clara Mullins, Sis	20b. F	Place of Dispos	sition (Na	me of	treet, B	altimo Date		D 21223 Location - City or	r Town. State
Baltimore,	permit. Pages 1 and 2 should be filed w Depertment of Health and Mentel Hygler Important: If Item 27 is marked other the eny Injury or other traumatic event, Illa ODGs.	1	1 Burial 2 Micromation 3 Re	emoval from State	emetery crem West Ar Cremato	unde ry	ther place		7-2006	Od	enton,	
Ba	Depermonent Deperm		Olling	X100 1/10)	111			nds Fry				
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O. Box 68760,	The law requires that the death certificate be executed tte has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗌	Ectopic p Other (s	pecify)	,		-	23d. Date of de Month	elivery Day Year
P.O.	that the		Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying	cause giv	en in Part I.	23e. [Did tobacco	use contribute	to the cause of death?
rds	aulres n sign	d by							100	☐ Yes 2	2 □ No 3 □ F	Probably 4 Unknown
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5.75	Physic this co	မှ	1 ☐XYes 2 ☐ No		ER/Outpatient			4 🗆 Nursing r				ecify) at scene
Olvision of V	inding l ath. r: After ie funer	Certification:	27. Manner of Death 1 Manatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of fnjury	М		yat k? Yes 2 □ No			ury occurred	
/ Orci	5 # 5 E	Certifi	4 Homicide determined	28e. Pface of fnjury - At h building, etc. (Speci	fy)				City of	Town, Sta	te)	Rural Route Number,
	Hospitel 24 hours a Funeral (edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ucian: To the best of my known or: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred estigation	at the tir n, in my o	me, date and place opinion, death occ	e, and due to urred at the ti	rne cause(me, date ar	s) and manner a nd place, and du	as stated. se to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29	c. Licens	se number		29d. D	ate signed (Mor	nth, Day, Year)
	⊢ > ⊢ ō		> Zahiela	3 AV			0.	C.M.E.		Feb	ruary 1	4, 2006
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Туре, 1 111 Ре	Print) enn S		et, Balti	more,			
	Sta Registi		31. Date filed (Month, Day, Year) FFR 1 6 2006	2. Registrar's Sign	ature	K						

			, roi	partment of Health and Nertificate of Death		iene •9.4006	04545
	Physici	20	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic		SULEIMAN MURSHED RAFIDI		January		
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
		jac .	Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Olney If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgo	nery hhptace (State or Foreign
	Funeral Director		579.58.8698 112 M 2 F 83 Yrs.	Months Days Hours Min.	Feb. 12,	Year) C	Birch, Jordan
**			Usual Residence of Decedent		100,12,	1722 01	Diren, oordan
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28a-f ehow fre Medical Exacitar must be rodified at		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	be filed within 72 hours after death with the Marylan Ital Hygliene. Id other than "natural", or liteme 23a or 28a-f ehow event, it a Madical Esaciliar must be notified at	cto	Maryland Montgomery Silver	Spring			1X Yes 2 ☐ No
	를 6 22 25	- E	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What 0	Country?
	ath w	Funeral Directo	3330 N. Leisure World Blvd., Apt#608			U.S.A.	
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	b. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specity:		Specify: W	hite
ခို	hour		15 Decedent's Education 16a Dec	edent's Usual Occupation		16b. Kind of Busines	s/Industry
15	in 72	Completed	(Specify only highest grade completed) (Gi	re kind of work done during most of work DO NOT use retired)	ring		
212	r the	E	Elementary/Secondary (0-12) Coflege (1-4or 5+)	Maitre d'		Restaurant	Services
ַ	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, I	Maiden Sumame)	
<u>a</u>	es 1 and 2 should be fi of Health and Mental H fitem 27 ie marked ot ir other traumatic ever	ToB	Murshed Salameh Rafidi	Nijmeh	Hanna	Ayoub	
ary	should have	-	19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Rui	al Route Number	City or Town, State,	Zip Code)
Σ	and 2 alth e 127 i		Jamal S. Rafidi/Son 220	Wimbledon Circle	. Silver	Spring, M	laryland 2090
ore.	of He of He item	1 2	20a. Method of Disposition 20b. Place of Discemetery, co	position (Name of ematory or other place)	Date	20c. Location - City of	r Town, State
Ĕ	Page net o int: if		LES DUTIAL & L. I CTOTTALION S L. I ROTTO VALITO III STATO		/2006 S	Silver Spr	ing, Maryland
altimore, Maryland 21215-0036	permit. Pages Department of h Important: if ite eny injury or of		21. Signature of Funeral Service License				
m	2253		Nancy A. Vacante 1	22. Name and Address of Facility INES-RINALDI FUNER 1800 New Hampshire	AL HOME, Ave, Si	ilver Spri	ng, MD 20904
4			23a. Part1. Enter the dispuse, or complications that ceused the death. Do not e shock, or head failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arri	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Respiratory Fail				Onset and Death
Part of	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner		Sequentially list conditions b. Hypercapnia				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypoventilation				
	ocute ind trans	Examin	that initiated events				
Š	ian a		resulting in death) Last Due to (or as a consequence of):				
8760	death certificate be executed e attending physician and ad for use as the burial-transit	dical	d.				
×	eath certific attending pl	Physician/Med	IF FEMALE:				
ROX	ath o	lan/		Ectopic pregnancy		23d. Date of d Month	elivery Day Year
		/slc	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)			
J.	The law requires that the ite has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23a Did tot	bacco use contribute	to the cause of death?
ecords,	signe d be	d by	Obstructive Sleep Apnea	and any my databat giran in a contract in			Probably 420Unknown
Ö	w requir been si should	etec	0 7 . 7				
ec	The law cate has I page 2 s	Completed	Congestive Heart Failure		24a. Was a autops perforr	sy prior to	autopsy findings available completion of cause of
<u></u>					1 □ Yes		s 2 No
Vital H	sician: certific irector.	Be	25. Was case referred to medical examiner?	Othor	h Check only on		
ō	Phy: this ald	٠ <u>.</u>	1 Minpatient 2 ER/Outpati	Bill SCIDON 4CINUISING IN		ence 6 Other (Sp ow injury occurred	ecify)
	ding l h. Alter funer	틸	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury		200. 2000. 20 110	ow injury occurred	
Division	Attending ir death. ector: Alter by the fune	flca	3 Suicide 6 Could not be 28e. Place of Injury - At home farm		28f. Location (St	treet and Number or I	Rural Route Number.
-	2 9	ertification;	4 Homicide determined building, etc. (Specify)		City or Town		
	spita nours neral	aC	29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the ca	ause(s) and manner :	as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, d	ate and place, and du	ue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mor	
	/	/		D-0061681		02/16/2	006
	1	(30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			1 00000
	フ		Robert David Kirkcaldy, MD, 18101	Prince Phillip Driv	re, Olne	y, Marylan	ld 20832
	Sta Registr		31. Date filed (Morth Day, Year) 32. F gistrar's Signature	heart .			

			For State Registrar	State of Marylar	d / Departme <i>Certifica</i>	ent of Health and ate of Death		giene () (6 04546
			1. Decedent's Name (First, Middle, Last)		4		2. Date of Dea Month		3. Time of Death
П	Physici /Medic		ROBER		RUS	SELL	Feb.		06 02:12 AM
	Examin		4a. Facility Name (If not institution, give st			ity, Town, or Location of Dea	th	4c. County of I	Death
			Baltimore Washing			en Burnie der 1 Year If Under 24 Hr.		Anne A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2□ F	Yrs. Month		. (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		219-20-7413 Usual Residence of Decedent	80			4/22/19	25N	laryland
	yland Now		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Man,	tor	MD Anne Arun	del Gle	n Burnie				1 □ Yes 2 □ No
	or 28;	Director	10e. Street and Number	, , , , , , , , , , , , , , , , , , ,		Zip Code		10g. Citizen of Wha	it Country?
	15 wil		906 Nabbs Creek R	oad	2	21060		USA	
	r dea	Funeral	11. IMBIRET States	Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
30	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give	1 ☐ Yes	s 2 No Specify:		Specify:	White
1215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at		15. Decedent's Educa	Year or Dates:	16a. Decedent's U	Isual Occupation		16b. Kind of Busin	
Ċ	in 72	Completed	(Specify only highest grade	completed)	(Give kind of life. DO NO	work done during most of w	orking	100. 74110 01 20011	ood mogotty
77	r than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Construct	ion Superinte	endent	Carpent	er
ַ	- 0 5	Bec	17. Father's Name (First, Middle, Last)		,			Maiden Surname)	
<u>a</u>		To B	Thomas F. B. Russ	ell, Sr.		Agnes 1	. Aymold		
Maryland 2	s 1 and 2 should f Health and Mer ltem 27 te marke other traumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Addr	ess (Street and Number or F	Rural Route Numbe	er, City or Town, Sta	ite, Zip Code)
	and and n 27 in 27 ier tra		Marydel J. Russell	/Spouse	906 Nabb	s Creek Road,	Glen Bu	rnie, MD	21060
altimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	Place of Disposition (cometery, crematory)	or other place)			
Ě	Pages ment of tant: If It		4 ☐ Donation 5 ☐ Other (Specify)	G1e	en Haven C		3/2006	Glen Burn	ie, MD
Ball	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lio Inse		22. Name	and Address of Facility	tallings	Funeral	Home, P.A.
	707 = 0		dy of My		3111	Mountain Rd	Pasaden	a MD 211	,
П			23a. Part1. Enter the disease, or comple shock, or heart failure. List only one	ations librat caused the deal e dause on each line.	in. Do not enter the n	node of dying, such as cardi	ac or respiratory ar	rest,	Interval Determen
)	Physician		Immediate Cause (Final disease or condition resulting in death)		ACUTE	MYOCARDIDE	INFASC	CHON	15 MINTES
	/Medical Examiner		700 Milling III dodaily	Due to (or as a consec	quence of):	RALIZED	ANT	1.050.20	2046018
П		4	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	Juence of):	The CIECY	1314 6	1405 4470	515 20/2000
	nsit	Examiner	cause, Enter Underlying Cause (Disease or injury		,				
·	be executed sicien and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):			····	
8760	death certificate be executed e attending physicien and d for use as the burial-transit	dlcal	d.						
Ó	tificat ng phy as th	led	(i)						
Box	leath certifici attending pl	an/N	230. Was decedent pregnant	c. If yes, outcome of pregnature 1 Live birth 2 Feta		cpregnancy		23d. Date o	•
	e death he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o				Month	Day Year
o.	et the de d by the a etached t	Ph	9 Unknown			Deal	Did to	abassa waa sastribu	ite to the cause of death?
Ś.	The law requires that the ste hes been signed by the page 2 should be detache	ρ	Part II. Other significant conditions cont	nbuting to death but not res	sulting in the underlying	ig cause given in Part I.			Probably 4 2 Unknown
5	w require been signature should b	eted	150 -00	COLOR	V CANCE				
ခ္	hes b	Completed	175 70179	OF PROST	Ast CAn	icen.	24a. Was autop	osv prio	re autopsy findings available ir to completion of cause of th?
Vital Records,	Physician: The la r this certificate hes ral director, page 2		Ky Pl	ELENDION.			1 Yes	200-No 1	Yes 2□ No
<u> </u>	sician certifi rector	Be	25. Was case referred to medi a examiner?	ospital:		Othor	eath (Check only o		
ō	Phys raldi	7	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOA 4 INDISING		dence 6 Other of the followingury occurred	(Specify)
o	ding h. After	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		, ,	
Division of	Atten deat octor	flca	3 Suicide 6 Could not be	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac	etory, office	28f. Location (S	Street and Number	or Rural Route Number,
á	al or after	Certification:	4 Homicide	building, etc. (Speci	fy)		City or Tov	vn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,					red at the time, date and pla			
	in 24 he Fu pletel	edical	(Check only 2 Medical Examin one)	ar: On the basis of examina and manner stated.	ation and/or investiga	tion, in my opinion, death oc	curred at the time,	gate and place, and	oue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (/	•
)			I I telle	7 11.1		y-2260	7	FGB 10	-2006
	6+1		30. Name and address of person who cor	1		6 A Dellar	00 - 01	A 1001 -	-2006 Md 21060
	21		31. Date filed (Month, Day, Year)	749 Registrar's Sign	· -	DRAW	401616N	DUNNIG	Ma 21060
- 32	Sta Regist		FER 1 6 2006	A Same A	book	1			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FEBRUARY 2006 5:58 PM ROOIJAKKERS MARIANUS PETRUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner National Institutes of Health Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 10 1956 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 310-23-5007 **Funeral** Days Hours 1⊠M 2□F 49 Netherlands Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Micdical Examiner must be nutitied at 90cg. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Indiana Wells Director Keystone 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 East 1000 South 46759 Dutch-Netherlands Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 🖾 No f Yes, Give 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer/Livestock Production Agricultural 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moeder Rooijakker Van Lijsse Jan Rooijakkers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jonny Rooijakkers / Wife 4020 East 1000 South, Keystone, Indiana 46759 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Inciana Date 20c. Location - City or Town, State 20a. Method of Disposition February 20 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Fort Wayne, Indiana ' 4 ☐ Donation 5 ☐ Other (Specify) 2006 Crematory Tnc. 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Inc. A. Pumphrey Funeral Homenc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01433 Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BACTERIA Physician SEVERE 4 NOUR S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit The law requires that the death certificate be executed and ng physician ar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months?

1 Yes 2 No
9 Unknown for 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 200No 3 Probably 4 □Unknown 1 🗌 Yes MELANOM Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 □ No 1 Yes certificate Yes or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ npatient 1 Tes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Leath 28b. Time of 28d. Describe how injury occurred Medical Certification: After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 } To the Fu 29d. Date signed (Month, Day, Year) 29b. Signature and title of bertifier 29c. License numbe 0106071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACOB KLAPPER 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 23161 Registrar

		í	1 - For State Registrar	State of N	/larylan		artment o			nd Me		iene	006	04548
			1. Decedent's Name (First, Middle, Las	•						2	. Date of Dea	th Day	Year	3. Time of Death
	Physici /Medio		Ruth	S.	Ro	binson				Fe	Month	7 8,	2006 ear	11:22 A M
1	Examin		4a. Facility Name (If not institution, give	e street and numbe	r)		4b. City, Tov	₩n, or Loc	cation of	Death		4c.	County of Deat	h
			Holy Cross Hospi	tal			Silver					Mo	ontgome	ry
	Funeral		5. Social Security Number 6. S	ex 7. A □M 2[XF	-	last birthday)	If Under 1 Y Months D		Under 2 lours	4 Hrs. 8	Date of Birth (Month, Day oril2,	Year)	9. Birt	hplace (State or Foreign ountry)
μđ	Director		376-07-0602		106	Yrs.				AI	pril2,	189	Penn	sýlvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	 -						10d. Inside City Limits
	Many	5	Maryland Montgome	ery	Ro	ckvill	е							1 Tyes 2 No
	1 the	rec	10e. Street and Number				10f. Zip Co	de			1	0g. Citi	zen of What Co	ountry?
	3a o	<u> </u>	4901 Adrian Stree	et			2085	53			U	nite	d State	es
	death ms 2	Funeral Director	11. Marital Status	12. Was Deceder	t Ever in U	.S. 13.	Was Decedent	t of Hispan	nic Origi	in? (Specif	fy Yes or No-		14. Race - Ame	nican Indian,
ဖွ	or ite	Ē	1 Never Married 2 Married	Armed Forces	No		f Yes, specify		pecify:	Puerto nit	can, etc.)	ŀ	Black, White	e, eic. hite
<u></u>	rei'.	d by	3 [™] Widowed 4 □ Divorced	If Yes, Give Year or Dates	:		10 105 20	1 140 3	p o city.				Specify: W	
5	tiled within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23a or 28a-f ehow ent, the Madical Examiraer must be nailliad at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usual O kind of work of DO NOT use re	ccupation	n ng most	of working		16b. Ki	nd of Business/	Industry
2	hen n	Ig II	Elementary/Secondary (0-12)	College (1-40	r 5+)	_						Dang	artment	Store
2	lled v tygie ther t	ပိ	17. Father's Name (First, Middle, Last)			Sare	spersor	-	Mothor	's Name //	First, Middle,			BLUTE
anc	tall H	Be		gerberg				16.	_	· ·	_		Surriame)	
<u>Ž</u>	d Med d Med mark matic	၉				10h Mailie	a Address (C	troot on d	Jeni		Peters		r Town, State, 2	Zin Codo)
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then. Important: If Item 27 is marked other then. Important: If Item 27 is marked other then. Important: If Item 27 is marked. Important: If Item 27 is marked. Important: Item 33 is not item. Important: Item 34 is not item. Important: Item 35 is not		Jacqueline M. Mal	opov/dau	and ohter	4901	Adrian							20853
Baltimore, Maryland 21215-0036	1 an Heeli em 2		20a. Method of Disposition	oney/ dad	20b. F	Place of Dispo	sition (Name o	of		Date	-		cation - City or	
o D	nt of nt of t: If it		1 ⊠ Burial 2 ☐ Cremation 3 ☐		9 0	cemetery, crer	natory or other .de Ceme	r place)		ebrua	ıry			nnsylvania
들	ortme ortani ortani		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		1101	_		-	, .	13, 20	000			·
Ba	Deperiment impo		John & Chap	MO	0092	R	ockv111	Le, M	lary.	Land	20850		gomery 2	uneral Home Avenue
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the deat line.	h. Do not ent	er the mode of	f dying, su	uch as c	ardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	Jehr	drat	10h							Onset and Doam
	/Medical Examiner		resulting in death)	Due to (or a	is a conseq	uence of):								
	Examiner	_	Sequentially list conditions,	b. Ine	· · · · · · · · · · · · · · · · · · ·	onia	1							
V	Page 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	A LA A	v (1 L	lear-	+ -	Die	nnis	50			
ľ	and and Il-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uende of);	1000	-	7	edi				
8760	death certificate be executed a stiending physician and dor use as the burial-transit	alE												
687	ficate physics the	edical		_ d										
Box	death certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date of dei	ivery
	death a atte d for	cla	in the past 12 months?	1□Live birth 4□Pregnant	at time of d		Ectopic pregr Other (specif						Month	Day Year
o <u>i</u>	at the de by the tached	hys	9 Unknown	9 Unknown										
ď.	The law requires that the site hes been signed by thi page 2 should be detache	ру Р	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying caus	e given in	n Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
Division of Vital Records,	w require been sig should b										1 🗆 Y	es 2[No 3□Pr	obably 4 Unknown
၀	s been 2 shout	Completed									24a. Was a		24b. Were au	utopsy findings available completion of cause of
æ	The lav	luo I									autops perform	iy ned? 2∭No	death?	completion of cause of
ā		BeC	25. Was case referred to medical	-				26	. Place o	of Death (Check only or		10,103	20,110
>	× 5 0	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatier	1 3 DOA	Othor					3 □Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	28c.	Injury at Work?			d. Describe h			
0	tendin Jeath. tor: Afi the fur	atlo	2 ☐ Accident investigation	ו	,	,,	М	1 🗌 Yes	2 🗆 N	0				
<u> </u>		# #	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of I	njury - At he etc. (Specif		eet, factory, of	ffice		281	f. Location (S. City or Town			ural Route Number,
Ω	ital or A rs after rai Dire led in b	Certification;			(- p = 5)									
	To the Hospital or within 24 hours afta to the Funeral Dircompletely filled in	edical	29a. Certifier 1 Certifying Ph	ysician: To the bes	of examina	owledge, death ition and/or in	n occurred at the vestigation, in	he time, d my opinio	date and on, death	place, and occurred	d due to the c at the time, d	ause(s) ate and	and manner as	s stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner	stated.		29c. Li	icense nu	ımber		2	9d. Dat	e signed (Mont	h, Day, Year)
	8 4 £ 4		A. 1.	1.1	1	1. 0		0019					uary 10	
,		1	30. Name and address of person who	UV V	dos d	U ax		.0013	, 0,		F	CDI	Jary IU	, 2000
	6		Franke Westphal,	•				d. S	te 2	202. 1	Rockvi	11e.	Marvla	and 20854
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa			-					<i>J</i>	
	Registr		FFR 1 6 200	0 1	1.	.50								

			For State Registrar	State of Ma	arylan	-	artmen tificate			and M	lental Hy	giene) 454	9
\$2	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month	Day		Year	3. Time of I	Death
	/Medic	al		Burges	s Elv	wood S				(D	Februa				5:15	AM
	Examir	er	4a. Facility Name (If not institution, given Greater Laurel H		hah	Canta		rown, or urel	Location o	of Death			County of		orge	
200		PHC.				ast birthday)	If Under		If Under	24 Hrs.	8. Date of Bir		_			Foreign
-	Funeral Director			X M 2 D E	31	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan 23	y, Year)	25	Cour Mary	lace <i>(Stat</i> e or try) land	
	P _		Usual Residence of Decedent													
	anylar ehow	<u>_</u>	10a. State 10b. County			, Town or Lo	cation							1	0d. Inside City 1 ☐ Yes	
	h the Maryland r 28a-f ehow incitiied at	ecto	MD Howard 10e. Street and Number		Laui	rel	10f. Zip	Codo				10a Cit	izan of Wil	nat Caus		- 41
	with	Funeral Director	9116 Gross Avenu	۵			207					U.S	izen of Wh	iai Cour	itty ?	
	ns 23	ега	11. Marital Status	12. Was Decedent	Ever in U.:	S. 13. V			spanic Ori	gin? (Spe	ecify Yes or No		14. Race			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 le marked other than "naturel", or Items 23a or 28a-f ehow any injury or other traumatic event, I're Madical Examinat must be notified at ance.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		f Yes, spec 1 □ Yes 2			i, Puerto	ecify Yes or No Rican, etc.)		Black,	White,		
21215-0036	2 hou	ed	15. Decedent's E	ducation	1742	16a. Deced	lent's Usua	I Occupa	tion			16b. K	ind of Bus			
215	nin 72 n "ne Medit	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or :	·	(Give life. L	kind of wor DO NOT us	k done di e retired)	u <i>ring m</i> osi	t of work	ng				,	
212	d with giene er the	E O	10	College (1-40)	,+,	Carp	enter					Co	nstru	icti	on	
Maryland	d oth	Be (17. Father's Name (First, Middle, Last								(First, Middle	, Maiden	Sumame)		
<u>X</u>	Meni Meni Marke	ို	Edgar Levi Sherm								Ross					
Mar	12 sh h and 7 le m rraum		19a. Informant's Name/Relationship	•			-				il Route Numb				Code)	
	1 and Health	-	Eva V. Sherman /	spouse	20b. P						, Mary		ZU/Z		wn State	
Baltimore,	ages nt of nt of r or o		1 XBurial 2 ☐ Cremation 3 ☐			lace of Dispo emetery, cren adowric					7, 06			-	yland	
IĦ	artme orten injun	}	4 Donation 5 Other (Speci	**	Med								ве у ,	ria1	yrand	
Ba	Depa Impo any is		De Delle Sel		M007	773 3.	13 Ta	lbot	t Ave	e. La	Iome, P urel,	Mary	land	207		
ģ.			23a. Part1. Enter the disease, or comshock, or heart ailure. List only	plications that caused one cause on each li	the death ne.	n. Do not ent	er the mode	e of dying	, such as	cardiac (or respiratory a	ırrest,		1	Approximate Interval Betwonset and D	/een
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Coronar	y Art	tery D	iseas	е							Orisot and D	
	/Medical Examiner		Tosuming in death)	Due to (or as												,
		<u>-</u>	Sequentially list conditions,	b. Hyperte											Several	_ yrs
14	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Arterio	sclei	rosis										
A.	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as												
760,	te be ysicia ne bur	cal	(_ d												
89	leath certifical attending phy I for use as th		IF FEMALE:									-				
Box	death certifica e attending ph od for use as th	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pro	egnancy					23d. Date Mont		•	ear
	0 0 0	/sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of de	eath 5□	Other (sp	ecify)					WORK		Day 1	bai
P.0	requires that the de een signed by the a nould be detached f	Completed by Physician/Med	Part II. Other significant conditions	contributing to death h	ut not resu	ulting in the ur	nderlying c	ausa auva	n in Part I		23e Did	Iobacco i	use contrib	oute to th	ne cause of de	eath?
ds,	w requires that been signed t should be deta	by	Diabetes Mellitu			-	idonying o	adso give	THE COLUMN						ably 4 □U	
Ö	- Q 70	ete	Atrial Fibrillat	ion			-				24a. Was					
Rec	e la has je 2	m D									auto		pri	or to co	psy findings a npletion of ca	use of
ā	icien: Th certificate rector, pag	e Cc	Parkinson's Dise	ase					26 Place	of Dooth	1 Yes	2 (2 No	1 [Yes	2 No	
>		To B	examiner? 1 Yes 2 XNo	Hospital:	ent 2 🗆 I	ER/Outpatien	t 3 🗆 DO	A Othe			me 5 Res		6 □Other	(Specif	/)	
Division of Vital Records,	79 00 0	ı.	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of Injury		Bc. Injury Work			28d. Describe				,	
jo	Attending r death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, , , ,	mjary	М		'es 2 □	No						
ivis	r Atte	Certification:	3 Suicide 6 Could not be determined		ury - At ho c. (Specify	me, farm, str	eet, factory	, office			28f. Location (City or To			r or Rura	l Route Numb)0 <i>f</i> ,
0	ital o															
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fun	edical	29a. Certifier (Check only one) 1 X Certifying Pl 2 Medical Exa	nysicien: To the best miner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurred : restigation,	at the time in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and) and <i>m</i> an d place, ar	ner as si	ated. the cause(s)	
	o the	Me	29b. Signature and title of certifier	12 100	2 - /		290	. License	number			29d. Da	te signed	(Month,	Day, Year)	
	~ > ⊢ 0		Alida	(Very e	n	ND		D212	94			Feb:	ruary	14	2006	
	120		30. Name and address of person who	completed cause of q	eath (Item	23a) (Type,	Print)									
	12		Abdul Nayeem, M.	D. 3450	ort M	Meade 1	Road,	Sui	te 10	00, I	aurel,	Mar	yland	20	724	
450	Sta	- 100	31. Date filed (Month, Day, Year)	32. Aug tstr	ar's Signat	ture	-10	9								
2	Registr		FEB 1 6	2000	and d	5. A										
DH	MH 17 Rev 1/2	3(31				S. Can										

1.			For State Registrar	State of M	larylan		artment of H			1ental Hy	- 1	nne	6	015	50
	4		Decedent's Name (First, Middle, Las	1)				- Joann		2. Date of De	Reg. N	<u>a. o o</u>	U.	3. Time of I	Death
	Physici /Media		Edward Paxton Smi	th						Februa	ry 1	ay, 20	006 006	2:00 F) м
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		of Death		-	c. County	of Death		
			11410 Rockville Pi				Rockvi					Mont			
	Funeral Director		012 30 3303	X 7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 02-07-1	y, Year	7)	9. Birth Cou New	place (State or intry) Jersey	Foreign 7
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						T	10d. Inside City	v Limits
	Maryl f sho	ğ	MD Montgome	ry		ckville								1 🗆 Yes	
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of W	/hat Cou	intry?	
	th witi	ai	11410 Rockville P	ike			20852				U.	S.A.			
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Iteme 23a or 28a-f show aumatic event, the Medical Examinar must be inclified at	Funerai	11. Marital Status 1 ☒Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 Tes ZZ	?	1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.))-	Blaci	k, White,		
9	urel',	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			☐ Yes 2X No	Specify:				Specify:	wni	te	
21215-0036	n 72 h	lete	15. Decedent's Ed (Specify only highest grad			16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation Juring mos	t of work	ing	16b. I	Kind of Bu	siness/Ir	idustry	
7	within ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 1 year	5+)	Draft		,			Enc	inoor	·i na	Compan	
2	Hygi other	0	17. Father's Name (First, Middle, Last)			Brait	Sman	18. Mothe	er's Name	(First, Middle				Compan	У
Maryland	dental Mental rked o	To B	Norman A. Smith					Dori	s Ko	one					
ar	s 1 and 2 should if Health and Men tem 27 le marke other traumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rura	al Route Numb	er, City	or Town, S	State, Zij	o Code)	
Σ.	and 2		Margaret Skovira			85 Ke	nnedy Wad	les M			aph	ine,	VA	24472	
Baltimore,	Pages 1 nent of H int: If fter		20a. Method of Disposition 1 □ Buriai 2 ☑ Cremation 3 □	Removal from State		emetery, cren	sition (Name of natory or other place			Date				own, State	
	permit. Pag Depertment Importent: eny Injury c ance.		4 □Donation 5 □ Other (Specify,		Met	ro Cre			2-16	-06	Bal	to.,	MD		
g R	permit. Pages Depertment of Importent: If it eny Injury or o		21. Signiture of Funeral Service Licens			Mi	Name and Addres	el Fu	uner	al Home	64	15 Be	laiı	c Rd	
			23a. Part 1. Enter the disease, or compositock, or heart failure. List only	lications that cause ne cause on each I	d the deatl ine.	h. Do not ente	the mode of dying	, scroll as	Cardiac o	or respiratory a	rrest,			Approximate Interval Between	reen
)	Physician		Immediate Cause (Final disease or condition				A Rise vlan							Onset and De	eath
	/Medical Examiner		resulting in death)	Due to (or as											
		76	Sequentially list conditions,	b. — Due to (or as	a consecu	uence ofi.									
de	bted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
٠ ا	exection and ital-tra	Exa	resulting in death) Last	c Due to (or as	a conseq	uence of):									
8/60,	cate be executed physicien and the burial-transli	dical		d											
0	ng ph	Med	IF FEMALE:		- 0	70				_	- 1			1.00	
SO.	at the death certific by the attending parached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)					23d. Date Mon		•	ear
	uires that signed b	by Pt	Part II. Other significant conditions co	ntributing to death b	out not res	ulting in the un	derlying cause give	n in Part I.		23e. Did t	obacco	use contri	bute to t	he cause of dea	ath?
Ē	w requires that been signed b should be deta	ed b								10	res 2	!□No	3 🗌 Prot	bably 4 🖃 Un	ıknown
Records,	e law has b	Completed									rmed?	de	eath?	opsy findings av	vailable use of
VII	ician: Th certificete rector, pag	0	25. Was case referred to medical					26. Place	of Death	↑ Check only o	2□No	11	Yes	2□ No	
<u> </u>	nysici nis ce direc	ToB	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatient	3□ DOA Othe			me 5 ☐ Resid		6 X Othe	r (Specif	w at sc	ene
on or	Attending Physician: r death. sctor: After this certific by the funeral director.	Certification;	27. Manner of Death 1 ★ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry y Yea <i>r)</i>	28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ h		28d. Describe	now inju	iry occurre	od		
UNISION	Attendii death. ctor: A by the fu	fica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho	ome, farm, stre	et, factory, office	65 2 🗀 1		28f. Location (Street a	nd Numbe	r or Rura	al Route Numbe	18 <i>1</i>
É	afor a after	ert	4 Homicide determined	building, ei	ic. (Specify	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tov	vn, Stat	e)			0.71
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy (Check only Wadical Exam)	sician: To the best	of my kno	wledge, death	occurred at the time	e, date and	d place, a	and due to the	cause(s	and man	ner as s	tated.	
	the H iin 24 the F	Medicai	one) A	and manner st	ated.	tion and/or inv	estigation, in my op	inion, deat	in occurr	ed at the time,	date an	d place, ai	nd due to	o the cause(s)	
	To To con	2	29b. Signature and title of certifier				29c. License						-	Day, Year)	
•			All hall Je	Myse	-D_			C.M.E		I	ebr	uary	15,	2006	
	3		30. Name and address of poor who co		death (Item	123a) (Type, F 111	r _{int)} Penn Str	eet,	Balt	imore,	Mar	yland	1 21:	201	
F	Sta		31. Date filed (Month, Day, Year)	2. Registr		ture	2,							***	
	Registr	ar .	FEB 1 6 2006	A STORE	15	Mark									

				partment of Health and Mertificate of Death	ental Hygier	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARYANN (Sicca			Day Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 2213 COROL HORN Rd.	4b. City, Town, or Location of Death Baltmore		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217-69-6299 1 M 2014 1 Yrs.		8. Date of Birth (Month, Day, Yei May 14,	ar) 9. Birthplace (State or Foreign Country)
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show r must be notffied at	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	tems 23	unerai	22.13 COROL HORN Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	2/226 3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9000	hours after tural', or ite al Examine	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh, K
21215-0036	within 72 ane. than "na'	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working. DO NOT use retired) IN FAN F	ng 16b.	Kind of Business/Industry INFANF
	ild be filed fentat Hygi ked other ic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	
Maryland	2 should by and Menta Is marked sumatic ev	P_C	11	iling Address (Street and Number or Rura		y or Town, State, Zip Code)
-	ges 1 and 2 should it of Health and Mer if item 27 Is marke or other traumatic		aomotoni a	a D Car F Ford 3	The state of the s	More 111 2/220 Location City or Town, State
Baltimore	Pa ant Lry		1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Crematory 2/18	3/06 0	Pathrnone, MD
Ba	permit. Deportr Importa any nji		Dittake mo1455	2134 Willow Spi	TING Rd.	21 Home, P.A. 21222
b	Priysician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	inter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	h.	_ 0.0000	COLLECTAL
V	t ansit	Examiner	Jaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	death certificate be executed e attending physician and od for use as the burral-transit	icai Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
9	ertificate ding physe se as the		IF FEMALE:			
P.O. Box	0 0	Physician/Med		B⊟Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
		ed by Pi	Part II. Other significant conditions contributing to death but not resulting in the ZECLWEGER SYNDROME	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	The law requires ate has been sign page 2 should be	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	sician: certific rector.	To Be (25. Was case referred to medical examiner? 1 Yes	26. Place of Death	(Check only one)	C TObas (Carata)
Division of	nding Phys th. :: After this e funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 2	28d. Describe how in	6 ☐Other (Specify) njury occurred
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, determinent to the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause and at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the To the comp	W	29b. Signature and title of certriff M.D.	29c. License number A 5 44 7359	70362	2-14-2056
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type ROUALD D. COHN 600 N WOLLE	Street Blalock	1008,3	collimore MD 21287
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Lail 5		
DHI	MH 17 Rev 1/20	001	FUD TO COUNT OF A			

ORIGINAL

			1- State Registrar	e of Maryland		artment of I		Mental Hy	giene Reg. No:	006	04552
	2.		Decedent's Name (First, Middle, Last)			C		2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Robert	W.		JNG	DOTS, SI	Februa	19 12	2006	18:23 M
	Examin		4a. Facility Name (If not institution, give street an	d number)			or Location of De	ath	4c.	County of Death	
	4		The Johns Hopkins H	tospital		Baltin		rty	45	N/A	
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. li	ast birthday) 68 Yrs.	Months Days			ay, Year)		place (State or Foreign ortry)
	Director		215-34-3469 Usual Residence of Decedent		68			JUL 1	1, 19	5/ Mary	/land
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 🗹 No
	ath with the Marylan 123a or 28a-f show ust be notified at	ctor	Maryland Frederick			Fre	ederick				
	or 28	Dire	10e. Street and Number			10f. Zip Code	0.4.		10g. Citi	zen of What Cour	ntry?
	ath w	Funeral Director	213 South Jefferson		0 140		21701	(Canada Van ar N		USA 14. Race - Americ	can Indian
	er de Rem	nue	Arme	Decedent Ever in U.: ed Forces? Yes 2 X No	5. 13.	was Decedent or f Yes, specify Cub	pan, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	Black, White,	
36	urs aft	by F	If Ye	s, Give		1 ☐ Yes 2 🂢 No	Specify:			Specify: Wi	nite
5-0036	be filed within 72 hours after death with the Maryland all hydrone did bylydene. I hat we do that than "natural", or terma 23a or 28a-f show other than "natural", or term as event, the Medical Evannian for must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple	atad)	16a. Dece	dent's Usual Occu	pation	working	16b. Ki	nd of Business/In	
2	thin 7	nple	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	life.	DO NOT use retire	∍ d)				D .
Maryland 2121	filed with Hygiene. other then	Co	12			Mechar		Name (First, Middle		omotive	кераіг
and	be de la pe	Be	17. Father's Name (First, Middle, Last)							oumano,	
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	s 1 and 2 should t Health and Mer itam 27 is marke other traumatic		Lillian May Snoots, N			_		Street			
re,			20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other pla		Date	20c. Lo	cation - City or To	own, State
Ĕ			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	-	ematory,		/15/06	Ba1	timore,	MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Puneral Service Vicensee	2.		. Name and Addr				,	MD, Inc.
<u></u>	20 E 2 9		Edward A. Grego					ad Balt		e, MD 212	
19			23a. Part1. Enter the disease, by complications shock, or heart failure. List only one cause	that caused the death on each line.			,		arrest,		Approximate Interval Between Onset and Death
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<u>ر</u>	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing	to death but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco u		he cause of death?
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٥	tal or A s after al Dirac ed in b)	Cert	4 Homelow	building, etc. (Specif)	·/			Only or 7	Juni, Otato	/	
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only 2 Medical Examiner: On	the basis of examinal							
	thin 2.	Medical	one) and 29b. Signature and title of certifier	manner stated.		29c. Licer	ise number		29d. Dat	e signed (Month,	Day, Year)
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	.0		30. Name and address of person who completed	CAL DOCTOR		Print)	5 - 000			ruary 1	-1
	IU			es Hopkins H	espital	600 North	a Wolfe Sy	treet . Bai	timorp	Marylan	rd 21287
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#3,pen/R, 0852,2/1//06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2006 3. Time of Death Day **Physician** Year 1:05 P M Margaret Violet Sye Feb. 14 1006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2□F Yrs. Director 188-18-4631 PA April 24 1923 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinations to infract Director 1 ☐ Yes 2 ☐ No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 2300 Dulaney Valley Rd. 21093 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown by informant Elizabeth Hottenfeller ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 sl to f Health an: If item 27 ie. 532 B Allegheny Ave., Sherry Kolbe/daughter Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite Burlet 2 Cremation 3 Removal from State 4 Disonation Other (Society) Metro Crematory 2/16/06 Catonsville, MD The of Fugo 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Lowell M. Lemmon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MIONONIS Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Directo (or as a nonsequence of): Examine burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the t use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. | the 9 Unknown Part II. Other stronficant conditions contributing to death' but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, TIEBMENS þ 1 Yes 2 No 3 Probably 4 nknown Completed 1853 28 rox-c 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check only one examiner Other. 1 ☐ Yes 2 → 46 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Division 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a entitying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature ar 29c. License number 29d. Date signed (Month, Dey, Year) .06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature Good ! Registrar

DHMH 17 Rev 1/2001

FEB 1 6 2006

FEBRUARY 14, 2006

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MARGARET

			For State	State of Marylan				Mental Hygie	ne n n s	01.551
		.,	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	Reg.	No.	04334
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	/Medie		4a. Facility Name (If not institution, give	JN III		4b City Town o	r Location of Death	7 i	4c. County of Dea	
	Examir	ier	FAIRLAND NILLES	ING LRELL	NR	SILVE	ED SP	2116	MONTAS	MIEDY
10.00	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		027-63-4385 15	M 219F 51	O Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, Ye	PEN PEN	NSYLVANIA
	p ,		Usual Residence of Decedent 10a. State 10b. County	10- 0	Ŧ					
	anyla ehov	5	N 4 > 1.		y, Town or Loc	cation				10d. Inside City Limits
	Me M	Director	MD MONTGE	JMFKA 10	EIHE	SODH				
	with Decr	ក់	10e. Street and Number	1100		10f. Zip Code		10g.	Citizen of What Co	ountry?
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·0	r iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Yes, specify Cubi	an, Mexican, Puert	Rican, etc.)	Black, Whit	
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7	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	distring those or work	9		1
	fied within 72 hours after death with the Maryland Hygiene. other then "naturel", or iteme 23a or 28a-1 ehow ent, the Madical Examiner must be indiffied at		17. Fathada Nama (First Atiddle 1 act)	5+	50	15011	51	G		MENT
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2	2 should and Men ie marke aumatic	으	19a. Informant's Name/Relationship (Ty	ne Print)	19h Mailin	n Address /Street	and Number or Bu	ral Route Number, Ci	ity or Town State	Zin Code)
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ē,	s 1 and 2 f Health item 27 i	1	20a. Method of Disposition	20b. P	face of Dispos	sition (Name of patory or other place		Date 20c	Location - City or	Town, State
Ë	Page lent o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State	ATOMY (00 10/10	SICIO HI	ALVILE	AM S
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		21. Signature of Funeral Service License			Name and Addre		ATOMY GIFTS	الرجاء عديات	1110
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat	h. Do not ente	r tne mode of dyir	ig, such as cardiac	or respiratory arrest,		Approximate Interval Between
ļ	Physician		Immediate Cause (Final disease or condition	Laryn	geal	Cane	y w			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):					
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9	ng ph	Med	IF FEMALE:							
Box	eath certific attending p	Ician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del	,
o.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5	Other (specify)			Month	Day Year
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Records,	uires I sign Id be	Completed by Physl		ghalopar	/ /	, ,		1 Tes	2 □ No 3 □ Pr	obably 4 Dunknown
Ö	w require been signature	ete			1			24a. Was an	24h Were at	itonsy findings available
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>	ysici lis ce direc	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Dth		ome 5 Residence	e 6 □Other (Spe	cifv)
0	ng Pt fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		28d. Describe how in		
Sio	eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division of	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Street City or Town, St		ural Route Number,
	pital ours arai filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	ulodgo dooth	and the sine sine sine	and data and class			
	To the Hospital or Attending Physician: which 24 hours after deals are dealing. To the Funaral Director: After this certifica completely filled in by the funeral director, to	Medical	(Check only 2 Medical Examir	er: On the basis of examinat	tion and/or inve	estigation, in my o	pinion, death occur	red at the time, date :	and place, and due	to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Monte	h, Day, Year)
			Balla -			128	6 56	FP	brugin	15,7006
	5		30. Name and address of person who co	npleted cause of death (Item	23a) (Type, P	Print) 1	4	IN P	1 1	· ani)
			KAUI Passi, N	10 8609	Seco	rd /r	e pe	704B 5	1077351	15,20910
400	Sta Registr		31. Date filed (Month Day, Gar) 6 2006	mpleted cause of death (Item	Page 4	K				
	- Contract Contract			-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** OWNE Ame 5 0057 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death WASh oleN Burnie SAITO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 M 2 □ F Director Yrs. 215-56-1992 Mar.19,1948 North Carolin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural" ---- any njury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Glen Burnie 1 TYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Sunny Brook Drive 21060 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 → Married 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Fork Lift Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James P. Townes Mary M.Alston Townes ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia 906 Sunny Brook Dr.Glen Burnie, Md.21060 Townes (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Greenwood Bap.Cem 2/19/2006 Warrenton, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility James E. Lincoln F/H PA Ave.Baltimore, Md. 21201 108 W. North 23a, Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on , ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician teriosclerotie /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, it any, teading to immudiate cause. Enter Underlying Cause (Disease or injury that initiated events Die to (or as a sonsequence of). Examiner anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificete 25. Was case referred to medical examiner?
1 △ Yes 2 □ No Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending investigation death. nerei Director: A 1 TYes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours after To the Funerei Dire the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Neg, MD Villiam 31. Date filed (Month, Day, Year) egistrar's Signature 32 State Registrar FEB 1 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Maryland / Department of Health and N State of Maryland / Department of Health and N Certificate of Death	Mental Hygie Reg.	2000	04556
	Physic		1. Decedent's Name (First, Middle, Last) EDNA TomLiNSON	2. Date of Death	Day Year 3 2006	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number) 2829 Lodge Farm Road BALTIMORE IN		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. $237-26-8296$ 1 Months Days Hours Min.	8. Date of Birth		place (State or Foreign intry)
	Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other then "naturel", or Items 23e or 28e-1 show treumatic event, the Medical Exams or countries or could be a	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Edgemere 10e. Street and Number 2829 Lodge Farm Rd. 10f. Zip Code 2/209 11. Marital Status 1 Never Married Named Forces 1 Never Married Never Married Never Married 3 Widowed Divorced Vear or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN 10c. City, Town or Location 2/209 10f. Zip Code 2/1209 11 Yes, specify Cuban, Mexican, Puerto 11 Yes, Specify Cuban, Mexican, Puerto 12 Yes or Dates: 15. Decedent's Education (Give kind of work done during most of work life. DO NOT use retired) Tex Hile Worker	pacify Yes or No- Prican, etc.)	Nanufac den Sumame)	ican Indian, , etc. Kife ndustry
	Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumstic angines.		19a. Informant's lame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	avenue,	Dandalle Location - City or T Baltman	Fown, State 10 2/222 10 M. P.A.
V	figure be executed times and the buriat-transit st the buriat-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ripry that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Pan Chronic Pan Chronic Pan Chronic Pan Chronic Pan Chronic Pan	or respiratory arrest,		Approximate Interval Between Onset and Death 2 m bs 3 mes 3 mes 3 years
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omlinson	II Records, The law requires to the law been signe page 2 should be	Completed by	arthritis	1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were au prior to death?	obably 4 Unknown topsy findings available ompletion of cause of
3	on of Vita ding Physicien: h. After this certific funeral director.	Certification; To Be (examiner?	th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, Street City or Town, S	injury occurred	Living Facility
	. Divisit To the Hospitel or Attentwithin 24 hours after dealt To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier 29c. License number	rred at the time, date	e(s) and manner as and place, and due Date signed (Month	to the cause(s)
	To To Cor	-	M. Wholevery Mg D45757			2006
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	St Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

	1.	For State Registrar			State o	f Maryla			ent of I			ental H	ygiene Reg. No			04557
Physician /Medical	1.	Decedent's Name	e (First, Middle	, Last)		S	Stella	Ucha	acz			2. Date of I Month Febru	Da	12, 2	Year 006	3. Time of Death
Examiner	4a	. Facility Name (II	f not institution	, give stre	et and nu	mber)		4b. (City, Town, o	or Location	of Death		40	. County of	Death	
		Greater			Lth &				Laure					Princ		
Funeral Director		Social Security No. 178-16-6	211	6. Sex 1 □ M	2 🙀 F	7. Age (In yr 85	s. last birtho	Mon	ths Days	Hours	Min.	8. Date of E (Month, Sept	Birth Day, Year, 29,	1920 N	Cou	olace (State or Foreigi ntry) York
	-	sual Residence of	Decedent 10b. County			10c. (City, Town o	Location								10d. Inside City Limits
f sho		MD	Howard	٦		E.	llicot	t Ci	F \$ 7							1 ☐ Yes 2 🕱 No
28a Perin	10	e. Street and Nun				12.	111000		. Zip Code				10g. C	itizen of Wh	nat Cou	ntry?
34 of all D		3351 Nor	th Chat	tham	Road	, Apt 1	E		21042				USA			
Depertment of Health and Mental Hygene. Important: if Item 27 Is marked other then "natural", or Items 23e or 28e-f show eny injury or other traumatic event, the Michael Examinar must be multiled at abbe. To Be Completed by Funeral Director	١.	. Marital Status 1 Never Marri 3 XWidowed			Was Dec Armed Fo 1 Tyes If Yes, Gir Year or D	2 (X No /e	U.S.	If Yes,	ecedent of I specify Cub es 2 X No	an, Mexica	in, Puerto	ecify Yes or I Rican, etc.)	No-		White,	
her then "nature ht, the Medical E Completed		(Spec	15. Decedent ify only highes ndary (0-12)	t's Educat st grade c	tion completed) College (1-4 <i>o</i> r 5+)	1 (0	ive kind c	Usual Occu f work done T use retire	durina mo	st of work	ng	16b. h	Kind of Busi		
Con	_	12					Hom	emak	er					wn Ho		
atic even	17	7. Father's Name (Michael		,								<i>(First, Midd</i> zurack		n Sumame,)	
E E E		9a. Informant's Na	me/Relations	hip <i>(Тур</i> е,	Print)		19b. N	ailing Ado	ress (Street	and Numb	er or Rura	l Route Nun	nber, City	or Town, S	tate, Zip	Code)
nar tra		Ronald U		/son		T				s Way		urel,	_			
nt: # Ite	20	a. Method of Disp 1 ☐ Burial 2 6 4 ☐ Donation	Cremation		noval from	State		rematory	or other pla			15, 06		.ocation - C nton,		
Importa eny inju	2	1. Signature of Fu	neral Savice	Licensee	1	M0(0773	Dona	and Address aldson Talbo	Fune	eral	Home, aurel,	P.A.	yland	207	707-4389
ysician Medical caminer	Ir d re	3a. Part1. Enter if shock, or hear mediate Cause (isease or condition sulting in death) equentially list cor any, leading to imause. Enter Unde	Final n	a b	Seps Due to Decu		equence of). ulcer		mode of dyi	ng, such a	s cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death
the burial-transit	th	ause. Enter Unde ause (Disease or lat initiated events esulting in death) L	injury	c	Due to	ure to orasacons othyroi	equence of)	ve								
should be detached for use as to the state of the state o	1F 2:	FEMALE: 3b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	230	1 ☐ Live I	tcome of preg birth 2 Fe nant at time of own	etal death		ic pregnand r (specify) _	у			-	23d. Date Monti		ery Day Year
		art II. Other signif	icant condition	ons contri	buting to d	eath but n <i>o</i> t r	esufting in th	e underly	ng cause gr	ven in Part	l.					the cause of death? bably 4 DUnknown
cate has been s page 2 should Completed					-							24a. W	as an	24b. W	ere auto	opsy findings available ompletion of cause of
page Con												1 ☐ Yes	rformed? 2 → N	o 15	ath?] Yes	2 🗆 No
ector Be	25	5. Was case reference examiner?		-	spital:				0+			(Check onl				
this or ral direction of To	27	1 ☐ Yes 2 ₹ 7. Manner of Deatl			1 🗆		ER/Outpa		JOOA			me 5 Re				fy)
After fune	-	1 🖺 Natural	5 Pendin investig	9	(Mon	of Injury th, Day Year)	Inju		28c. Inju Wo	rk?]Yes 2.[200. 10030111	O HOW HIJE	ary occurre	u	
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		2 Accident 3 Suicide 4 Homicide	6 Could determ	not bo	28e. Place build	of Injury - Ating, etc. (Spe	home, farm						(Street a		r or Aur	al Route Number,
pletely fille		9a. Certifier (Check only one)	1⊠ Certifyin 2 Medical	g Physic Examine	r: On the b	best of my k asis of exami ner stated.	nowledge, o	eath occur r investiga	rred at the tation, in my	me, date a opinion, de	nd place, ath occurr	and due to the	ne cause(: e, date ar	s) and mand nd place, an	ner as s	stated. to the cause(s)
To th comp		9b. Signature and	Anya of certifier	60	un	AH	end	mg.	29c. Licen D425							Day, Year)
4	30	0. Name and addr Parmjit							lis R	oad,	Suite	e 13,	Blade	ensbui	rg,	MD 20710
State	3	1. Date filed (Mon.	th, Day, Year)	6 21	705 ^{32. F}	Registrar's Sig	nature	1	all s							

DOB 09-29-1920 Stella. Uchacz

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ORIGINAL

		,	1 - For State Registrar	State of Mar	•		nt of Health and te of Death		giene Reg. No.	006	04559
		15	1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	ath Day	Vose	3. Time of Death
	Physici			Portia	Jeann	ie Wi	lliams	FEB	13,	2006	10:19 PM
	/Medic Examin		4a. Facility Name (If not institution, given	ve street and number)		4b. City	, Town, or Location of De	ath	4c. (County of Death	
		7.00 m. 	416 Ripplewoo	d Road			Joppa			Har	ford
	Funeral			Sex 7. Age ((In yrs. last birthda	Months	r 1 Year If Under 24 H Days Hours Mi		th ly, Year)	Cou	place (State or Foreign intry)_
	Director		193-36-4/8/		59 Yrs			JUL 4	194	6 Penn	sylvania
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	r Location					10d. Inside City Limits
	eho	5	MD Harf		,.		Joppa				1 ☐ Yes 2 🔀 No
	the N	ect	10e, Street and Number	ord		10f Z	p Code		10a. Citiz	en of Whai Cou	intry?
	death with the Maryland ms 23a or 28a-f ehow rimust be notified ≝t	Funeral Director	416 Ripplewood	d Road			21085			USA	•
	ns 23	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 1	13. Was Dece	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No)- 1	4. Race - Ameri	
_		T I	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No				erto Rican, etc.)		Black, White	, etc.
รัก	al', o	by	3 ☐ Widowed 4 ☐ X ivorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 XNo Specify:			Specify: R1	ack
15-003b	d within 72 hours after death with the Marylan jiene. I than "naturel", or Items 23a or 28a-f show the Madical Exeminar must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	ecedeni's Usi	ual Occupation ork done during most of w use retired)	vorking	16b. Kir	nd of Business/Ir	ndustry
N	ithin Ben Mar	npje	Elementary/Secondary (0-12)	College (1-4or 5+)) life				D1. 7	: 01	7 0
7	filed within 72 hours after Hygiene. ither then "netural", or Ite int, the Medical Exemina	Co		5+		1	eacher	lame (First, Middle			ol System
yland	be fill	Be	17. Father's Name (First, Middle, Las.							ŕ	
	J Mer J Mer nark	은	Alber				s (Street and Number or	zabeth_		oraney	
<u> </u>	d 2 st h and 7 ls r traur		19a. Informant's Name/Relationship Tamala M. Byro			_					
	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		20a. Method of Disposition	i, Sister	20b. Place of Di	sposition (Na	Dlewood Ro	Date JO	20c. Loc	cation - City or T	1085 own, State
Baitimore,	00-		1 ☐ Burial 2 X Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci			crematory or Cremat	ory, Inc. 0	2/15/06	R	altimor	o MD
	nit. Page partment portant: If injury o		21. Signature of Funeral Service Lice						Soc	iety of	MD Inc
ğ	Dep Con		I Seon E.	May 14/2			299 Freder				MD 21228
п		ří .	23a. Part1. Enter the disease, or con shock, or heart lailure. List only	nplications that caused the	he death. Do not	enter the mo					Approximate Interval Between
	Dhusisian			one cause on each line	;						
1			Immediate Cause (Final	Matad	hatic E	3 no a	at Canal	nema			Onset and Death
100	Physician /Medical		disease or condition resulting in death)	a. Metas Due to (or as a	consequence of):		st Canci	noma			
No.		V.	disease or condition resulting in death)	Due to (or as a			st Canci	nema			Onset and Death
	/Medical Examiner	ner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a			st Canci	noma			Onset and Death
	/Medical Examiner	aminer	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a b Due to (or as a c	consequence of):		st Canci	noma			Onset and Death
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Q Q	/Medical Examiner prize and prize transit	cai	disease or condition resulling in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequence of):		st Canci	noma			Onset and Death On whear
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Box 68	/Medical Examiner prize and prize transit	cai	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of	consequence of): consequence of): consequence of): f pregnancy Fetal death		pregnancy	noma	2	:3d. Date of deliv	Onset and Death On whe are
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.06.

		•	For State Registrer	State of Mary		epartment of t Certificate of				elien n p	04300
f	Dhualai	149	1. Decedent's Name (First, Middle, Las	,					Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic			lliams				F€	bruary		
	Examin	er	4a. Facility Name (If not institution, give			4b. Cily, Town,				4c. County of D	
×			Genesis Brightv 5. Social Security Number 6. S		n yrs. last birth		nervi]	r 24 Hrs. g	Date of Birth	9	1timore
100 mg/s	Funeral Director		219-18-5355	ox 7. Age (/		Months Days		Min.	Month, Day, 1 arch 30),1917	Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town	or Location					10d. Inside City Limits
	Maryi	Į.	Maryland N/A		Bal	timore					1 XYes 2 ☐ No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What	Country?
	h with		5802 Hamlin Avenu	ıe .		212	15			USA	
	ams	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S.	13. Was Decedent of If Yes, specify Cut	Hispanic Or	rigin? (Specify	Yes or No-		merican Indian, /hite, etc.
0000	lid be filed within 72 hours after death with the Maryland fental Hygiene. rked other than "natural", or itams 23e or 28e-f ahow it event, the Medical Examinations with be invitted at	þ	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No					Black
ה ה	72 ho	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. (Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during mos	st of working	1	6b. Kind of Busine	ss/Industry
7	within han '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	lite. DO NOT use retire Iomemaker	ed)			Own Hon	10
7	Hygie Hygie Thert	ပိ	12 17. Father's Name (First, Middle, Last)		Γ.	lomemaker	18 Moth	er's Name (Fi	rst. Middle, M.	aiden Sumame)	ie .
yiana	d be anntal	Be c	Charles Garrett					Mary			
2	2 should be and Mental is marked (ဌ	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Stree	t and Numb			City or Town, Stat	e, Zip Code)
N	D = N =		LeEster Clay, Daug	ghter	580	2 Hamlin A	venue	Baltir	more, M	Maryland	21215
ē,	s 1 er f Hea item othe	1	20a. Method of Disposition			Disposition (Name of crematory or other pla		Date		0c. Location - City	
Ē	Page nent c int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			rematory I		2/11/0)6 E	Baltimore	e, Maryland
baltimor	permit. Pages 1 en Department of Heali Importent: if Item 2 eny injury or other once.		21. Signature of Funeral Service Lice Thomas Gregor	Juga-		22. Name and Addr Cremation 299 Frede	oss of Facili	ety Of	Maryla	and Inc.	and 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Don	ot enter the mode of dy	ing, such as	s cardiac or re	spiratory arres	st,	Approximate Interval Between
	* Physician		Immediate Cause (Final	one cause on each line.	. 1						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of	f):					0472
	Examiner		O	, H7	N						4 EAR3
7	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence o	1):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cCA	D						YEARS
Ď,	cien a	ũ	resulting in dealiny cast	Due to (or as a c							YEARS YEARS
08/00,	ificate be executed g physicien and as the burial-transit	edicai		d. <u>UC</u>	men	FUC					9000
-	= 0,00		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy					23d. Date of	delivery
X D	requires thet the death cert. een signed by the attending hould be detached for use i	by Physician/M	in the past 12 months?	1☐Live birth 2 [4☐Pregnant at tim		3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су			Month	Day Year
j	at the de by the a	hys	9 Unknown	9□ Unknown							
, T	w requires that s been signed b should be deta	y P	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying cause g	iven in Part	1.	23e. Did toba	acco use contribut	e to the cause of death?
ğ	en sig								1 ☐ Yes	2 □ No 3 □	Probably 4 Onknown
Records,		Completed							24a. Was an autopsy		autopsy lindings available to completion of cause of
	The ate h page	Com							perform	ed? deat	
VII	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?					e ol Death (C	heck only one)	
	his b	၉	1 ☐ Yes 2 X No	Hospital: 1 Inpatient		DATION 3 DOA				nce 6 Other (5	Specify)
001	fe fe	ation:	27. Manner of Death 1	1	e <i>ar)</i> 28b. Ti	jury We	uryat ork?]Yes 2. [. Describe hov	v injury occurred	
DIVISION OF	after de Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (· At home, far Specify)	m, street, lactory, office		281.	Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ā	(Charle out) OF Madical Even	ysician: To the best of r		the terror of earlier to be			A Ale - A		al. a ha his district of h
	To the within 2 To the comple	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 h Allunia A. Culta 9650 5 And 1 A. Color State 29c. License 31. Date lifed (Month, Day, Year) 29c. License 32c. Registrar's Signature 32c. Registrar's Signature					se number		29	d. Date signed (M	onth, Day, Year)
i	F ≯ F 3		Snipy			000	531	570	6	PR 119n	7006
	. i		30. Name and address of person who	completed cause of deat	h (Item 23a) (1	Type, Print)	- 71			COL	INRIA
	H		SHARUNITALA	QU?TA 9	650 5	ANTIAGO	ROA	to, 5	UITE	110	21015 OM
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's	Signature	sale)					
12	Registr	ar	FEB 1 6 2006	The Contract of	9						
011				-							

	1 - For State of Maryland / Department of Health and M Certificate of Death	Reg. No.	
Physician	1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year 3. Time of De	ath
/Medica	EUGENE ALFRED TOUNG	February 11 2006 9:00 1	P M
Examine	Springbrook Adventist Nursing Home Silver Spring	Montgomery	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplece (State or For Country)	oreign
Director	235.18.8692 84 Yrs.	April 1, 1921 Stanaford, V	√V
land	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City L	imits
Mary B-f sh	Maryland Montgomery Silver Spring	1 ☆]Yes 2[No
vith the Ma	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
a 23a		U.S.A.	
of the state of th	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		
urs a very	1 Yes 2 № No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates:	Specify: White	
72 hours 72 hours "natural", edical Exe	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b. Kind of Business/Industry	
	Elementary/Secondary (0·12) College (1·4or 5+) 8th College (1·4or 5+) Taxi Driver	Transportation Ser	vice
ind Z be filed v tal Hygie d other t event, E	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maiden Sumame)	, 100
Vian Wental Mental Milc av	Frank Young Annie	Mae Johnson	
ore, Maryland 2 ss 1 and 2 should be filed of Heelth and Mental Hygie filem 27 is marked other r other traumatic avant, the	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i>		
	Patricia Y. Stonebanks/Daughter 416 Marshall Manor Dri	ive, Silver Spring, MD 2090 Date 20c. Location City or Town, State	05
Baltimore, Dermit. Pages 1 ar Depertment of Hee Important: If Item: Inty injury or othe	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		
Baltimo	21. Signature of Funeral Service Licerse) 22. Name and Address of Facility HINES—RINALDI FUNERA	_	
n asisa	11800 New Hampshire	Ave, Silver Spring, MD 209	04
	23a. Part1. Enter the chaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heaft failure. List only one cause on each line.	_ Interval Between	en
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Lung	Disease Many	,-S.
Examiner	Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying		
50, Control of the executed sicien and purial-transit	Cause (Disease or injury that initiated events resulting in death) Last		
Phy cat	d.		
BOX 6 eath certifi attending for use as		23d. Date of delivery	
Hecords, P.O. BOX The law requires that the death cert ste has been signed by the attending age 2 should be detached for use a	in the past 12 months? 1	Month Day Yea	r
P.O. het the de de by the sidetached i	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat	h2
VItal HECOrds, P slclan: The law requires thet certificate has been signed to irector, page 2 should be det	Anemia, Dementia, Coronary Artery	1 Yes 2 No 3 Probably 4 Unki	
w require to been siles should it	Disease, Basal Cell Carcinoma	24a. Was an 24b. Were autopsy findings ava	
The law cete has to page 2 s	of mose	autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	e of
	25. Was case referred to medical 25. Place of Death	Check only one	
Of Vital Physician: rithis certifice ral director, p. To Re C.	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)	
ding Alte	27. Manper of Death 28a. Date of Injury 28b. Time of Injury at Work? 2 Accident investigation M 1 Year)	28d. Describe how injury occurred	
JIVISIO or Attendenti efter death Director: In by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number	
DIV setter setter ad in br	4 Homicide determined building, etc. (Specify)	City or Town, State)	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director. Medical Certification: To Be		and due to the cause(s) and manner as stated.	
within 24	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)	
T 3 7 8	D3100	1	
ŋ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	February 14, 2006	
	Stuart J. Turkewitz, M.D., 7500 Greenway Center Dr.,	#430, Greenbelt, MD 20770	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Danielma			
Registrar	FEB 1 6 2006		

					partment of Health and Mo		3		
	316		1- For State RegistrAmend Item #8	B Per FH G852 2/10			R.() () 6	04562	
	Physici /Medic		1. Decodent's Name (First, Middle, Last)	Zuaer		2. Date of Death Month 2	Day / Year 2 00/	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	2	
46			101 South Meadow D		Glen Burnie		Anne Arı		
	Funeral Director		5. Social Security Number 1 6. Sey	M 2XF 7. Age (In yrs. last birthday	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept.26		place (State or Foreign intry) PA	
	/land		10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits	
	Man	to	MD Anne Arun	del Glen Bu	ırnie		1 ☐ Yes 2 No		
	or 28	Jirec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	untry?	
	23a	rai	101 South Meadow 1		21060		U.S.A.		
	er de	une		12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	offy Yes or No- lican, etc.)	14. Race - Amer Black, White		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. Or it filem 21s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marucal Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	te	
21215-0036	2 hou atura ical E	ted	15. Decedent's Edu		edent's Usual Occupation	16	b. Kind of Business/Ir		
215	fhin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	e completed) (Giv Iife. College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired)	4		·	
S	Hygiene. Hygiene. sther that	Con	12	Off	ice Manager	-	rucking		
nd	tai Hidi	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	iden Sumame)			
7	should be ind Mental inarked o umatic eve	2 L	John Kabo	200	Margaret				
-10	d 2 sho th and the ma traum		19a. Informant's Name/Relationship (Ty		iling Address (Street and Number or Rural South Meadow Drive				
	Health Health tem 27 other tr		Mr. John Zuger / I 20a. Method of Disposition	20b. Place of Disp	position (Name of Da		rnie, MD c. Location - City or T	21060 own, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ematory or other place) The Cremation 2-18-2		ttsburgh,		
alti	permit. F Departme Importer any injur		21. Signature of Funeral Service License		22. Name and Address of Facility Sing				
ä	Depar Impo		Stannonis		1 Second Ave, SW G			1061	
8	* * * * * * * * * * * * * * * * * * * *		23a. Part1. Enter the disease, or compli		nter the mode of dying, such as cardiac or			Approximate Interval Between	
F	hysician		Immediate Cause (Final disease or condition	Respialar	dishess			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	, , , , , , , , , , , , , , , , , , , ,			14	
\$	zxammer	Į,	Sequentially list conditions,	NAULO				1 /	
. 1	ed sit	Examiner	Sagus Itally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
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68	ifficate g phy as the							16.11-1-1202	
Вох	The law requires that the death certifications the has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	very	
	o deat	sicis	in the past 12 months? 1 Yes 2 No		Other (specify)		Month	Day Year	
P.0	that the de led by the a detached f	Phy	9 Unknowh						
S,	res that signed t		Part is Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	V	co use contribute to		
orc	w requir been si should	etec	A Land	Pulla possi	1.004.0	1 X Yes		bably 4 Unknown	
Records,	has l	Completed by	Sugarview	mor count	noma	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of	
			25. Was case referred to medical			1 Yes 2	No 1 ☐ Yes	2 No	
Vital	Physician: The law this certificate has b ral director, page 2 s	To Be	examiner?	fospital:	ent 3 DOA Other: 4 Nursing Horn	1	0.500		
o	- a	n: T	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at 2	8d. Describe how	e 6 Other (Speci injury occurred	ify)	
io	ath. r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 Yes 2 No				
Division	r Atte er de recto	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s	street, factory, office 2	8f. Location (Stre City or Town,	et and Number or Run State)	ral Route Number,	
	to the Composition of the Compos								
	29a. Certifier (Check only one) 20a. C				nd due to the cau	se(s) and manner as a	stated. to the cause(s)		
	thin 2 the orthogonal	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Month,		
	F ₹ 5 8		NA IIIX IAA	PUMALIE!	742/60	290) /12/7/	06	
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type	Peint) O-1	2 00	-117/20	100	
30. Name and address of person who completed cause of death (Item 23a) Gype, Brint) FITH HAIZEN/FR , 22 Courty (Treller Steel) Balliman, 102				or, MD2	120/				
State 31. Date filed (Month, Day, Year) 72. Begistrar's Signature				-					
State 31. Date filed (Month, Day, Year) 72. Begistrar's Signature									

			1 - For State Registrar	State of Mary		partme				ntal Hyg	jiene leg. No.	006	04563
4	Physici		1. Decedent's Name (First, Middle, Las Ruth Stanner Ande	,					2.	Date of Dea Month	Day	Year 200	3. Time of Death
30	/Medic Examin		4a. Facility Name (If not institution, give			4b. Ci	y, Town, or	Location of C	Death	0 1	-	County of Dea	
100	6 8 W. s.		Shady Grove Adven	tist Hospita	1	Roc	kvill	.e			Moı	ntgome	ry
	Funeral Director		5. Social Security Number 6. S 357-07-0409	ex 7. Age (In ☐ M 2 ☐ F 87	yrs. last birthda Yrs.	(y) If Unc Month	er 1 Year s Days		Min.	Date of Birth (Month, Day ct. 1,	, Year)	9. Bi	rthplace (State or Foreign ountry)
	pue A		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or	Location							10d. Inside City Limits
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itama 23a or 28e-f ahow surnatic avant, its Madical Examinar must be notified at	ro	MD Montgom		Potoma								1 ☐ Yes 2 X No
	r 28e	Funeral Director	10e. Street and Number		Tocomo		Zip Code			1	10g. Citiz	en of What C	country?
	th with	al D	11801 Enid Drive					20854	,		Unit	ted Sta	ates
	ems .	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 1	3. Was Dec	edent of Hi	spanic Origin n, Mexican, P	? (Specify	y Yes or No- an, etc.)	1	4. Race - Am Black, Wh	
36	s afte	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give			2 No	Specify:				Specify:	White
0	tural	ed b	15. Decedent's Ed	Year or Dates:	16a De	cedent's U	sual Occupa	ation			16h Kin	id of Busines:	
212	nin 72 in "ne Medit	plet	(Specify only highest gra		(Gi	ve kind of	vork done d use retired,	furing most of	f working				a massify
21,	giene gritha	Completed	Clementary/Secondary (5-72)	2	Веа	utici	.an				Cos	smetolo	ogy
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's					
yla	f Men marka natic	70	Thomas Bernard S							xis Ba			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28e-f ahow among injury or other traumatic avant, the Madical Examination at a once.		19a. Informant's Name/Relationship (1 Sharon Lea Johns					ind Numbero Live P				Town, State, 0854	Zip Code)
re,	f Heal		20a. Method of Disposition		b. Place of Dis	position (A	ame of		Date	7		ation - City o	r Town, State
E	Page In to Man t		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		сөтөtөгу, с Gate of			1.6	въ. 3 2006	,	Silv	er Spi	ring, Md.
Baltimore,	apartir aporta ny inju		21. Signature of Funeral Service Licen	\$ 90				s of Facility					-
	20 E E 9		Colot A. h	rkol	- I							sburg,	Md. 20877
2			23a. Part1. Ever the disease, or comp shock, or heart failure. List only	olication) that caused the one cause on each line.	death. Do not e	enter the m	ode of dying	g, such as car	rdiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Anc	100to	ma							8 days
	Examiner			Due to (or as a cor	isequence of):								
		Jer	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying	b. Dua to (or se s cor	esquence of):								
	cuted nd transit	Examiner	that initiated events	c									
8760,	cate be executed physiclen and i the burial-transit	EX	resulting in death) Last	Due to (or as a cor	sequence of):								
87	physicate to physical	dlcal		d									
9 X	certifi ding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro	egnancy						2	3d. Date of de	disease
Вох	that the death certific led by the attending p detached for use as	Physician/Med	in the past 12 months?	1 Live birth 2 □. 4 Pregnant at time		3 ☐ Ectopic 5 ☐ Other (Month	Day Year
<u>Р</u> .	by the	hys	9 Unknown	9□ Unknown									
s,	res tha igned be det	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying	cause give	en in Part I.			1		to the cause of death?
ord	w requir been sl should l	sted							-	1 🗆 Y	es 2	3 No 3 □ F	robably 4 DUnknown
3ec	e law has b	Completed								24a. Was a autops perfori	ŞY	24b. Were a prior to death?	utopsy findings available completion of cause of
a	n: Th ficate or. pag		26 Man ann afarrad be a shad							1 ☐ Yes	2 No	1 🗆 Ye	s 2 No
Ξ	s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatient	2 🗌 ER/Outpat	ont 2 I	Othe	26. Place of				□Other (Spi	
l of	g Phy er this eral c		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time	of	28c. Injury Work		-	. Describe h			9CITY)
ior	ttendin death. stor: Aft / the fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	ir) Injun	y M		res 2□No					
Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Attert his certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, pecify)	street, facto	ory, office		28f.	Location (S. City or Tow			Rural Route Number,
	pitei ours a erel D		29a. Certifier Certifying Ph	veining: To the best of mu	knowledge de	-1b	d - 4 4 - 4 - 4 -				- ()		
	o the Hospitei thin 24 hours a the Funeral I mpletely filled	Medical	(Check only Z Medical Examone)	ysician: To the best of my liner: On the basis of examination and manner stated.	nination and/or	investigation	on, in my op	onion, death c	occurred a	at the time, d	ause(s)	and manner a place, and du	e to the cause(s)
	To the within ?	Me	29b. Signature and title of certifier			2	9c. License			2	9d. Date	signed (Mon	ith, Day, Year)
)	15		▶ ATUD				6	3Z6	53		1/	31/2	2006
			30. Name and address of person who	completed cause of death			C 1	- D	alla	200	Lil	Lahai	2085D
100	* 64	•	31. Date filed (Month, Day, Year)	32/Registrar's S		lical	cent	a Di	IVE	-, KOC	KVII	1614	20000
	Sta Registr			006	J. A	OSALL!	7						

			State of Maryland / Department of Health and M			01 100
	A		1 = Former State Amended 24a, 24b, 1/31/06, LDB, Certificate of Death		9. No.	04564
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	h Day Year	3. Time of Death
	/Medio	cal	Charles Andrew Abt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Jan.	26 2000 4c. County of Death	
	Examir	ier	CAL TODUDY DEVID A AND COLO	004		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	804 8. Date of Birth (Month, Day,	Year) Col	iplace (State or Foreign Intry)
\	Director		219-28-6193 TAM ZELF 72 Yrs. Usual Residence of Decedent	Aug. 10,	1933 Mary	1ánd
8	Maryland I-f show first at	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
R	h the Marylan r 28s-f show inculfied at	ecto	Maryland Dorchester Hurlock			1 ∑Yes 2 ☐ No
34	€ 0 2	i Di	45 Delaware Avenue, Apt. 1 21643	10	0g. Citizen of What Coi USA	intry?
1	er death w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1953— If Yes, specify Cuban, Mexican, Puerto	ocify Yes or No-	14. Race - Amer Black, White	
36	s after	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1955 1 □ Yes 2 □ No 1 Yes, Give 1955 1 □ Yes 2 □ No Specify: Year or Dates:	,,		hite
才是	72 hours after natural', or ite	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation	1	16b. Kind of Business/I	
1215	within 7 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			
121	0 0 =	Cor	12 Delivery Man 17. Father's Name (First, Middle, Last) 18. Mother's Name			et Products
land	ed ala	To Be	Frederick William Abt Anna Hild		laidon Gamamo)	
Ce C Maryl	d 2 should be th and Mental 7 is marked of traumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		City or Town, State, Z.	ip Code)
6, N	s 1 and 3 if Health item 27 other tri		C. Dwayne Abt/Son 4972 Rhodesdale-Eldorad 20a. Method of Disposition 20b. Place of Disposition (Name of			
Jou nou	8 - = 0		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City or 1	
Baltimor	그 든 만든		21. Signature of Fineral Service/U ic 4 see		eulah, Mary	
<u>~</u>	Depa Impo		Zeller Funeral Home 106 Main Street, Ea	st New M	Box 207 Market, MD	21631
		,	23a. Pay1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause of each line.	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Other and a large disease or condition	2		onsot and poatin
	Examiner		Due to (or as a consequence of)		1	
	D 15	iner	Sequentially list conditions, if any, leading to infinitediale cause. Enter Underlying Cause (Disease or injury that initiated events C	21	1	
	e be executed /sician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	Samo	y Dina	
_	e be e /sician e buriz	a	d	/	/	
Вох 68	th certificate ending physi r use as the b	Medi	IF FEMALE:			
B0)	eath ce attend for use	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delik	∕ery Day Year
P.O.	the de by the ached	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown			
S,	res that the de signed by the a i be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	
Division of Vital Records,	w requir been si should	Completed		1 🗆 Ye	s 2□No 3⊡1Pro	bably 4 □Unknown
Bec	The law sete has t page 2 s	mpi		24a. Was an autopsy perform	prior to p	opsy findings available ompletion of cause of
ta	lcian: Th certificete rector, pag	Be Co	25. Was case referred to medical 26. Place of Death	1 Yes 2	No 1 √7es	X □ No
<u>></u>	Physician: this certific al director,	To B	examiner?		nce 6 Other (Spec	fy)
o u o	ding Ph h. After th funeral		1 Conversal 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	w injury occurred	
isic	or Attendio ter death. Irector: A Irector: A	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury. At home, farm, street, factory, office 2	28f. Location (Stre	eet and Number or Rui	al Route Number,
á	rs after safter blue blue blue blue blue blue blue blue	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	, State)	
	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the car ad at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
_	To the within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	Day, Year)
			029849	9	426/01	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/	/ 6	
16.	S Sta	te.	21 Date filed (Month Day Voor) 22 Projetrate Signature	804		
A Section of the sect	Registr		JAN 3 1 2006 Sz. Helistal a signature			

		ı	For State Registrar	State of Ma	arylan			nt of Healt te of Dea		/lental Hy	/giene	2000	04565
			1. Decedent's Name (First, Middle, Las	st)					_	2. Date of D			3. Time of Death
	Physicia /Medic		Brenda Lee	Booke	er					JANUARY	31	200	6 00:59 M
į.	Examin	er	4a. Facility Name (If not institution, give	, ,	1	/	4b. City	, Town, or Locat	tion of Death		4c.	County of Dea	th .
	C		VENINS Wa REGIONO 5. Social Security Number 6. Se	NEDICAL EX 7. AG	e (In vrs.	ast birthday)	If Unde	SUISDUI or 1 Year If Un	der 24 Hrs.	8. Date of Bi	irth	WICONI 9 Bird	hplace (State or Foreign
	Funeral Director			□ M 2 🔀 🖛	43	Yrs.	Months	Days Hou	urs Min.	8. Date of Bi (Month, D	ay, Year) 22 1	962 Ma	aryland
	pu »		Usual Residence of Decedent 10a, State 10b, County		10a Cib	y. Town or Lo	anation.				-		
	f show	ō	_	vi ao	100. 010								10d. Inside City Limits 1 XYes 2 □ No
	28a-1	Directo	Maryland Wicom 10e. Street and Number	1100		Sali	1	ip Code			10a. Citi	izen of What Co	ountry?
	h with		620 Baker Stre	et				21804				S.A	,
	deati	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13.	Was Dece	edent of Hispanio	c Origin? (Sp	ecity Yes or N		14. Race - Ame Black, Whit	
92	or ite	by Fu	Never Married 2 Married	1 ☐ Yes 2 ★ N If Yes, Give Year or Dates:	10		1 Tes			, , , , , , , , ,		Specify:	
Ö	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show ent, it a Medical Exant not must be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed			16a Dece	dent's lis	ual Occupation			16h Ki	B I	lack
<u> </u>	n "na n "na Medic	Completed	(Specify only highest gra-	de completed)		(Give	kind of w	ork done during use retired)	most of worl	king	100.10	ild of business	industry
212	filed with Hygiene other the	Eo	10	College (1-4or 5	(+)	Do	mest	ic				None	
2	0 T D A	Be	17. Father's Name (First, Middle, Last)					18. M	lother's Nam	e (First, Middle	e, Maiden	Sumame)	
<u>₹</u>	2 should be and Mental Is marked o	ဥ	Leonard Waters			1				cia An			
Ma	d 2 st th and 17 ts n traun		19a. Informant's Name/Relationship (7 Winston Cook Jr				-	s (Street and Nu			-		Zip Code) 7 , Md 21801
Baltimore, Maryland 21215-0036	es 1 and 2 should to of Heeith and Mant itam 27 is marked rother traumatic		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei				Date		cation - City or	
E E	Pages nent of int: if it iry or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify					otner piace) ve Cem	2-6-	-06	Wes	tover,	ЬМ
a	permit. Pages Department of Important: if i any injury or o		21. Signature of Funeral Service Licen	see 2 .	6	2:	2. Name a	nd Address of F	acility				
<u> </u>	8828		Hladys B	Stewa	N		821"	art Fu West R	d.Sa	isbur	y,Md	.21801	
ī	_		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death	n. Do not en	ter the mo	de of dying, such	h as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Seeding.	Physician		Immediate Cause (Final disease or condition resulting in death)	a SEP.									HOURS
	/Medical Examiner		ſ	Due to (or as			Pame	4					VELOC
	· ·	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as			7-17						16 1157
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ŏ,	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequ	uence of):							
8760	physic physic s the b	dical	•	d									
× 6	ding Se a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of del	ivery
Box	atte	iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic p ⊒ Other (s					Month	Day Year
0.	by the de	hys	9 ☐ Unknown	9□ Unknown									
	The law requires that the ste has been signed by the bage 2 should be detached.	۵	Part II. Other significant conditions co	ontributing to death be	ut not resi	ulting in the u	inderlying	cause given in P	art I.				the cause of death?
Ö	w require been si should b	Completed									Yes 2	□No 3□Pr	obably 4 Unknown
Ş	has b	m pi								24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
a		င္ပ	25. Was case referred to medical							1□ Yes	5K) No	1 ☐ Yes	2□ No
5	s cert direct	To B	examiner?	Hospital: 1X Inpatie	nt 2 □	ER/Outpatier	nt 3 🗆 D			h <i>(Ch</i> eck only		6 □Other (Spe	ciful
<u></u>	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		28b. Time o		28c. Injury at Work?	-	28d. Describe			Sily /
S	uttendir death. ctor: Al y the fu	catic	2 ☐ Accident investigation				М	1 ☐ Yes	2 □No				
Division of Vital Records,	- 0 -	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. <i>(Specif</i>)	ome, farm, sti /)	reet, facto	ry, office			(Street and wrn, State		ural Route Number,
_	To the Hospital of within 24 hours aft To the Funeral Di completely filled in		29a. Certifier 1 Certifying Phy	ysician: To the best of	of my kno	wledge deat	h occurre	at the time date	e and place	and due to the	Cause/e\	and manner or	stated
	Hotely	edicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examina	tion and/or in	vestigatio	n, in my opinion,	death occur	red at the time,	, date and	place, and due	to the cause(s)
	withir comp	ž	29b. Signature and title of certifier	Α.	1 ^	D.		c. License numb	ber		29d. Dat	e signed (Mont	h, Day, Year)
	2		1- mierte	ory , 1	(.V.	, Ph.	v.	1158	689			-31-20	06
	7/2		30. Name and address of person who d	completed cause of di	eath (Item	23a) (Туре,	Print)		3 -	SAUSKI	ini	M	
	Sta	to.	31. Date filed (Month, Day, Year)	KOSZ, M	ィン。 ar's Signa	ture	<u>~</u> . s	nore.	Dr.	5,400-00	19		
	Registr		FFR 0 2 2	nns A		KA	Coasts	B					

1 - For State Registrar

			1 - For State Registrar			Certificate of	Death		Reg.(No.)	0 04566
	Physici	an	Decedent's Name (First, Middle, L.	,	*			2. Date of De.		3. Time of Death
ž .	/Medic	cal	Mildred C. 4a. Facility Name (If not institution, gi	Boone		4b City Town	or Location of Death	Januar	4c. County o	2006 10:49 M
	Examin	ier	Doctor's Hospi	·		Lanham	or Location of Dogin	,	PG	. Bouil
4.4	Funeral Director		217-34-2176	Sex 7. Age (In 1 M 2 XF 69	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb 9	th y, Year) ,1936 M	9. Birthplace (State or Foreign Country) arylan d
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
	Mary a-f sh	tor	Md PG	La	anham					1 XYes 2 □ No
	with the 3e or 28a	Funeral Director	10e. Street and Number 6807 Gairlock	Place		10f. Zip Code 20706			10g. Citizen of W	hat Country?
	death	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No	- 14. Race	- American Indian,
020	in 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show koften Examiner, and be multing at	þ	1 ☐ Never Married 2 ☐ Marned 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No		rrican, etc.)		, White, etc. Black
2-003		etec	15. Decedent's E (Specify only highest g.	Education rade completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of work	ring	16b. Kind of Bus	siness/Industry
7	filed within Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retire erk	id)		US Post	al Service
7 0	illed within Hygiene. other then	4	12th 17. Father's Name (First, Middle, Las	st)	CIT	21 1/	18. Mother's Nam	e (First, Middle,	Maiden Sumame)
and and	Mental Mental rked c	ToB	William F.	Marshall			Cecelia	a Stew	art	
Mary	and N		19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Address (Street	and Number or Rur	al Route Numb	er, City or Town, S	State, Zip Code)
	and 2 ealth n 27 I		Albert R.Marsh							
baltimore	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 le marked other then eny Injury or other treumetic event, ITEM DRCe.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State M	cemetery,	isposition (Name of crematory or other pla nd Nat Ce	ice) Tools	06 06	Laurel	City or Town, State Md •
Dalt	permit. Departn Importe eny Inju		21. Signature of Funeral Service Lice	Bell &		22. Name and Addre	,	719 Ke	nnedy S	Wash DC St. NW 20011
3	1 A M		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused the	death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	y one dadd on dadn line.	n		. ($\overline{}$		Onset and Death
					14.4	2501ra	10Y7 1	Ta. Iv	re	
	/Medical		resulting in death)	Due to (or as a co	-	spira		railu		
	/Medical Examiner	Į,	resulting in death)	b	-			-		7
· ·	Examiner	niner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		-			-		7
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/on,	Examiner	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co	onsequence of	noxic		-		7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		irtment of H <i>tificate of I</i>			ne . n. 2006	04567
(E)	- 2.		1. Decedent's Name (First, Middle, Las	0				Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	200	Jessie Lee E	Briscoe				January		6 6:59P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral	(3) -	Prince Georges 5. Social Security Number 6. Se	7. Age (In yr	enter s. /ast birthday)	If Under 1 Year	verly If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	Prince 9. Bir	Georges thplace (State or Foreign puntry)
	Director		427-62-3684	X M 2□F	72 Yrs.	Months Days	Hours Will.	Oct.16	.1933	MS
	p ,		Usual Residence of Decedent 10a State 10b County	100	City, Town or Lo	4'				10d. Inside City Limits
	anylar ehov	_	10a. State 10b. County	100. (ity, rown or Lo	cation				1 Styles 2 No
	8a-f	Director	DC	W	ashing					
	with the		10e. Street and Number			10f. Zip Code			. Citizen of What C	
	234	ra	5228 Karl Plac	CE, NE 12. Was Decedent Ever in	12 12 1		019		nited St	
5	in 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow Indical Evantination invitited at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc.
2-003b	tural E		15. Decedent's Ed		16a Deced	lent's Usual Occup	ation	16	b. Kind of Business	ack
Ċ	filed within 72 Hygiene. Ither then "nai	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of	during most of work	ing	o. rand or business	, modeliny
7	there	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Lab	Technic	ian	н	ealth &	Human Serv
0		0	17. Father's Name (First, Middle, Last)		Бав	100111110		e (First, Middle, Ma		
Maryland	d a d a	To B	Joseph Brisco	e			Lela	Otley		
2	is 1 and 2 should of Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	and Number or Run	al Route Number, (City or Town, State,	Zip Code)
Ž	and 2 Balth a n 27 is		Bertha Briscoe	/wife	5228	Karl P	lage, 20	E19		
စ်	Hea Hea tem othe		20a. Method of Disposition	206	Place of Dispo	sition (Name of	20	Date 20	c. Location - City or	Town, State
9	ages ent of it: If i		1 Surial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify	Removal from State		natory or other place coln Cem	1 - 1 - 1	06 B:	rentwood	d. Md.
Baltimore,	permit. Pages Depertment of P Important: If ite eny injury or of once.		21. Signature of Funeral Service Licen		22	. Name and Addre	1			F.H. Md. 20746
	40200		So Planton Co	aucuas		10 Silv				Approximate
			23a. Part. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.				or respiratory arres	t,	Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	a FATAL CAP	DIAC +	4RRHYTHA	114			
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	st.	_	Sequentially list conditions,	b	CIL/ICCCCCQ40					
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_	eath certific attending p		IF FEMALE:	23c. If yes, outcome of preg	nancy				Ond Date of de	· Fire and
gog	death of attentions and for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe	atal death 3	Ectopic pregnancy Othar (specify)	1		23d. Date of de Month	Day Year
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Division of Vital Records,	: The law cate has t	ldu						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
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Ĭ	Attending Physician: Thir death. c death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	1 04		h (Check only one))	
ō	Phys this at dir	2	1 183 2 190	1 Inpatient 2	V ER/Outpatier		4 Nursing no		ce 6 □Other (Sp	ecify)
<u></u>	ding F h. After funer	on o	27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how	infury occurred	
<u>s</u>	Attend er death rector: / by the f	cat	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 □No	201 1 1 (0)		
\leq		Certification:	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, str cify)	eet, factory, office		City or Town,		Rural Route Number,
	urs a			1						
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	yeician: To the basis of exam and manner stated.	nation and/or in	h occurred at the lift vestigation, in my c	ns date and 1903 ppinion, death occur	red at the time, dat	me(s) and makiner a e and place, and du	is stated ie to the cause(s)
	To the Within 2 To the complet	Z	29b. Signature and little of certifier	/		29c. Licens	se number	290	d. Date signed (Mor	nth, Day, Year)
) AX/L	777		D5	8957		1-30-	06
D	(10)		30. Name odress of pers of who	completed cause of death (I	em 23a) (Type,	Print)	_			-
-	(1)		DR GARY /LITTLE	3001 H	BSPITHL	DRIVE	CHEVI	ERLY. MD	20185	
36	Sta	ate	31. Date filed (Month, Day, Year)	3001 H	nature					
	Regist	rar	PEB 0 2 200	6 detre 1	A April	(2)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFH, C853, 3/2/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 29, 2006 **Physician** L. 7:00A Samuel Burton January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1220 Firth of Lorne Circle Fort Washington
If Under 1 Year | If Under 24 Hrs. | 8. [Prince Georges 5. Social Security Number 227–22–9682 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 €M 2 □ F Months Days Hours Min. Yrs. 227-22-9282 April 20,1925 VΑ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. PG Fort Washington Direct 10e. Street and Number 10g. Citizen of What Country? 1220 Firth of Lorne Circle Funeral 20744

13. Was Decadent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed by Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Burton ဂ္ Nancy Gales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Firth of Lorne Circle Washington, Maryland Date 200. 1220 Fort Magnolia Burton/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 2/7/06 Suitland, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 1 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Anset and Death 23a. (2art). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate Hears Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medica IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 Yes 2√2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Funeral

Director

and Mental Hygiene.
Is marked other than "natural" or Items 23s or 28s-f show is marked other than "natural" or Items 25s or 28s-f show raumatic event, the Madical Exacilities marked for inclined at

within 72 hours after death

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permit. Pages 1 and 2: Depertment of Health ar Important: if item 27 ie any injury or other trau once.

Physician

/Medical

Examiner

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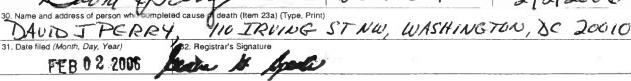
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Division

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2006



DC-18561

			1- For Amend Item 21 State of Maryland / Department of Health and Mental Hygiene per FH, G853, 03/16/06dhb of Death		
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Anuary 287 3 oct 1836 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death		
	Funeral	er	Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months, Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)		
	Director	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinan must be maillied at	rai Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 North Locke Wood Road 21921 USA		
9036	ours after de tral', or items Examiner o	d by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1		
21215-0036	filed within 72 h Hygiene. ther than "natu int, Ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Home		
Maryland	s 1 and 2 should be if Health and Mental itam 27 is merkad o other traumatic eve	To Be C	17. Father's Name (First, Middle, Last) Charles A. Allen 18. Mother's Name (First, Middle, Maiden Sumame) Bonnie Dohl		
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21921 Donald J. Beazley (Husband) 50 North Locke Wood Road, Elkton, MD 20a. Method of Disposition 1 Paurial 2 Cremation 3 Removal from State		
Baltimore,	permit. Pages Department of I Important: If its any injury or o		Bethel Cemetery Feb. 2,06 Chespeake City, MI 21. Signature of Funeral Service Licensee CO442 Robert Strawbridge per DVR Robert Strawbridge per DVR Robert Strawbridge Per DVR Robert Strawbridge Per DVR		
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Council Counci		
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.O. Box 6	ath certifi ttending or use as		hysician/Me	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Records, P.	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
tal Rec		e Completed	24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)		
ion of Vital	ding Phys h. After this funeral dii	ation; To Be	examiner? 1 Yes 2 1 To Pending 2 Accident investigation Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Fending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No		
Division	i Site	il Certification;	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or within 24 hours afte To the Funarel Director completely filled in the Funarel Complete	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)		
)	F 3 F 8		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOS 8354 January 19 1006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEIL E. LATOLD MD LOI COLONIAL Way, Rising Sun, MD 21911 31. Date filed (Month, Day, Year) 32. Registrar's Signature EFR 0.2 2006		
	12	10	DEIL E. LATOIN MD 101 COLONIAL Way, Rising Sun, MD 21911 31. Date filed (Month, Day, Year) 6 32. Registrar's Signature.		
	Sta Registi		EER 0.2 2006 Heave & Species		

		State Ragistrar		d / Departme	ent of Health and ate of Death	Mental Hy	giene	
70	-	Decedent's Name (First, Middle, Last)	001111100	no or boarr	2. Date of De			
Physicia	an		1 11			Month	Day	'ear
/Medic		INCZ Eliz	LAbeth			2	T	06 2317 M
Examine		4a. Facility Name (If not institution, give street and n		1	y, Town, or Location of De		4c. County of	
		Upper Chesapeake Med			Bel Air			arford
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	Month	der 1 Year If Under 24 H s Days Hours Mi		th ly, Year)	Birthplace (State or Foreign Country)
Director		210-10-0711	84	Yrs.		8/18	/1921	Maryland
p .		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Location				10d. Inside City Limits
anyla	_		Toc. City,	, TOWN OF LOCATION	-			1 ☐ Yes 2 X No
9 W	ç	MD. Harford			Jarretts	AITTE		TE TOS EMITO
or 26	Director	10e. Street and Number		10f. 2	Zip Code		10g. Citizen of Wh	at Country?
15 w	a	2227 Schuster Ros	ad		21084		Unite	d States
dea	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S orces?	3. Vas Dec	cedent of Hispanic Origin? Decify Cuban, Mexican, Pur	(Specify Yes or No	14. Race	American Indian, White, etc.
after or the	교	1 Never Married 2 Married 1 Yes	2 X No	ŀ	2∭∑No Specify:	0.00	Specify:	·
00 and 10	ð	3 ☐ Widowed 4 X Divorced Year or	Dates:	10.00	Egg No openiy.		Зреспу.	White
23 (7 1215-0036 within 72 hours after death with the Maryland ene. than "netural", or items 23s or 28s-f show than "metical Examinat must be notified at	etec	15. Decedent's Education (Specify only highest grade completed	(1)	16a. Decedent's Us	sual Occupation work done during most of w use retired)	vorkina	16b. Kind of Busi	ness/Industry
7 7 E	현		(1-4or 5+)	life. DO NOT	use retired)			
21 21 Signal with the state of	ĕ	11 ()	Fa	rmer		Fa	rming
and 21215-0036 be filed within 72 hours after death with the Marylar tial Hygiene. Ind other than "neturel", or freme 23a or 28a-1 ehow event, the Medical Exportment number from the motified at	Be Completed by	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle	. Maiden Sumame,	
Aents Aents rked tice	To E	Henry Davis	Wal	beck	Blancl	ne Al:	media 🔻	Corbin
re, Maryland re, maryland s 1 and 2 should be file Health and Mental Hy ttem 27 is marked oth other treumatic event		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addre	ess (Street and Number or	Rural Route Numb	er, City or Town, S	tate, Zip Code) 21084
		Brenda K. Hicks/Dat	ughter	2227 Sc	huster Rd	. Jar	rettsvi	lle, Md.
Baltimore, M. Baltimore, M. Semit. Pages 1 and 2 Separtment of Health a mportant: If them 27 is nay injury or other treases.		20a. Method of Disposition	20b. Pla	ace of Disposition (N	lame of	Date	20c. Location - C	
O O O O O O O O O O O O O O O O O O O		1 Burial 2X Cremation 3 Removal from		metery, crematory of		7/2006	Hamnat	and Marrian
Baltimor. Baltimor. permit. Pages Department of himportant: # ite eny injury or of		4 Donation 5 Other (Specify)	Mar.					ead, Marylan
Bal		21. Signature of Fundral Service (censee	the six					Maryland
4		11. Marinen Du	771	E.G	. Kurtz &	Son Fu	neral H	
		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t daysed the death. I each line.	. Do not enter the m	ode of dying, such as card	iac of respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Reso	tomy	Failune Heart rtery Do Inface			Criser and Doutin
/Medical		resulting in death) Due to	o (or as a consequ	ence of):	. /	2 /		
Examiner		Sequentially list conditions	Cong	estime	HEART	toelun	e	
0 17 5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a consequ	ence of):				
Tans rans	m	Cause (Disease or injury that initiated events	Cana	nous A	rtery We	DEAS &		
60, Cbe executed be executed burnal-transit		resulting in death) Last Due to	o (or as a consequ	ence of):				
	cal	U d	Muo	candial	Tru lanc	tion		
N 2003(2) P.O. Box 687 thet the death certificate ed by the attending phys detached for use as the	ed							
Box Box sath cert	Z		utcome of pregnar				23d. Date	of delivery
B B B	Cla	in the past 12 months?	birth 2 Fetal gnant at time of de				Mont	h Day Year
the chart	ıysi	9 Unknown 9 Unk	nown					
of Vital Records, P.O. Box 68 Of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	by Physiclan/Med	Part II. Dther significant conditions contributing to	death but not resu	Iting in the underlying	cause given in Part I,	23e. Did	tobacco use contrib	oute to the cause of death?
ecords, law requires t as been signe 2 should be c	D D					10	Yes 2□No 3	Probably 4 Unknown
Or requ	etec					-		
Vital Record Vital Record ician: The law require certificate has been si	Completed					24a. Was	psy pri	ere autopsy findings available or to completion of cause of
Fhe The page	Con					1 Yes		ath? ☐ Yes 2 ☐ No
Vital B	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only	one)	
direction of the second of the	Jo.		Inpatient 2	P/Outpatient 3 1	DOA Other: 4 Nursing	Home 5 Res	idence 6 Other	(Specify)
on of Sing Physical distributed distribute	=		e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	1
Indian Indian Indian Indian	읉	1 Naturat 5 Pending (Mc 2 Accident investigation	M	1 Yes 2 No				
Division or Attending after death. Director: After lin by the fune	flea	3 Suicide 6 Could not be determined 28e. Plan	ce of Injury - At hor	me, farm, street, facto	ory, office	28f. Location	Street and Number	or Rural Route Number,
Division Division Division Uns after death. erel Director: Af	Certification:	4 Homicide determined buil	tding, etc. (Specify,)		City or 10	wn, State)	
Hospitel Hospitel 24 hours & Funerel I tely filled	0	29a. Certifier Sertifying Physician: To ti	he best of my know	viedge, death occurre	ed at the time, date and pla	ice, and due to the	cause(s) and man	ner as stated.
Comercy Inc. 2 Division of Vita To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On the	basis of examinati inner stated.	ion and/or investigation	on, in my opinion, death or	curred at the time,	date and place, ar	d due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							(Month, Day, Year)
F3+8		1 Stower 2 Joseph no 000 36487 2/10/0						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
6			se of death (Item	ZJa) (Type, Print)				
Sta	i e		Registrar's Signat	ure 🎤 👗				
Registra		FEB 1 6 2006	me to	ande!				

			For State Registrar	State of M	laryland /	-	artmen rtificate			ind M		giene	106	01.571									
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last Dwight Bentley As. Facility Name (If not institution, give	Cordell)				Location o	of Death	2. Date of Dea Month Januar	ath Day	Year 200(County of Dea										
	Funeral	eı	Washington Coun 5. Social Security Number 6. S	ty Hospita	a.] ge (In yrs. last b			erst			8. Date of Birt	W	ashing	thplace (State or Foreign									
	Director	Irector	185–34–3147 1 Usual Residence of Decedent 10b. County	X]M 2□F	62						Sep. 13	3, 19	43 Mer	Cersburg, PA									
altimore, Maryland 21215-0036	th the Mary or 28a-f eh e rollfied		MD Washing		Hager	sto	10f. Zip					10g. Citize	en of What C	1 ☐ Yes 2 ☐ No ountry?									
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23e or 28e-f ehow other traumatic event, the Medical Exeminations the rollified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1 XYes 2	? No		Was Deced	rify Cubai	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ecity Yes or No Rican, etc.)	. 14	ted St 4. Race - Ame Black, Whi	erican Indian, te, etc.									
	within 72 hours ene. then "naturei", he Medicel Ext	Completed by	3 ☐ Widowed 4 ⚠ Divorced 15. Decedent's Ec (Specify only highest gra Elementary Secondary (0-12)	Year or Dates:	16a	a. Dece (Give life.	dent's Usua kind of woi DO NOT us	I Occupa	ition furing most	of worki	ng	16b. Kind	d of Business	hite /Industry									
land 21	uld be filed w Mental Hygies irked other ti	To Be Co	17. Father's Name (First, Middle, Last) Clarence Cordell			Inkn	OWII				(First, Middle,		nown Gumame)										
e, Mary	1 and 2 shoul Health and M em 27 is mart ther traumati		19a. Informant's Name/Relationship (Sharon R. Miller 20a. Method of Disposition	Type, Print) Niece	1	.21 (Green	neado	ow La:	ne C	A Route Numbers	bur		7201									
altimor	permit. Pages Department of I Important: If its any injury or or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer	y)	20b. Place cemete Howar	d Me	edica.	L Sch	1001	v *	0/06	Wash	ningto										
B I			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	d the death.	not ent	AUSTII 3821 ter the mod	1 KOY 14th e of dying	yster St.] g, such as	Fund NW_Wa Cardiac o	eral Ho ashingt r respiratory ar	me on, I rest.	OC 200	Approximate Interval Between Onset and Death									
P.O. Box 68760,	death certificate be executed Water transition as the burial-transit Water to see as the burial-transit	Exa	Еха	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence	of): \$\frac{1}{2} \text{ of):}	out	o W	-	dr	10NA N	1 100	DONE	years years								
	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		e of pregnancy 2 Fetal deat tt time of death		Ectopic pro					23	3d. Date of de Month	livery Day Year									
	law requires that the as been signed by th 2 should be detache	Certification; To Be Completed by	Certification: To Be Completed by	Certification; To Be Completed by	Part II. Other significant conditions o	ontributing to death	but not resulting	in the u	nderlyin g ca	ause give	on in Part I.			es 2		o the cause of death?							
Vital Records,	The te h				Certification; To Be	To Be	To Be	To Be	To Be	To Be	To Be	25. Was case referred to medical						OC Plane	of Dooth	1 🗆 Yes	rmed? 2 No		utopsy findings available comptetion of cause of
of	Phys this aldi											ToB	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1		utpatier Time o Injury		Bc. Injury Work	or: 4 □ Nui	rsing Hon	(Check only one 5 ☐ Resident Person of the	lence 6
	S ir te					3 Suicide 6 Could not be determined	building, e	ijury - At home, f tc. (Specify)						City or Tow	n, State)		ural Route Number,						
	To the Hospitei within 24 hours a To the Funeral Completely filled	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best niner: On the basis and manner s	of examination a	nd/or in	vestigation,	in my op	oinion, deat	h occurre	ed at the time, o	date and p	signed (Mont	e to the cause(s)									
)			30. Name and andress of person who		death (Item 23a)	(Type,	Print	1)	41	18	6	1	127	106									
10000	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 20	320 Regist	rar's Signature	6	21 (JA	16 1	M /	ONT	1+	109e	1021742									

	01010 icine Cur	nir	Please T ngham Unpend item#23a,PI	ype or Print 1,27,28a-f State of Mar	in Black In en/E,G852,2 yland / Den	delible Inl	c. Ensure A	II Copies	Are Legib	le.	
_			1 - State Registrar			ertificate of			Reg. No. 0 0	6 04572	
	Physici	an	1. Decedent's Name (First, Middle, Last) CAPICINE CELONIA	ry 8, 2006	3. Time of Death 9:31 P M						
E.	/Medic Examin		4a. Facility Name (If not institution, give s	CUNNINGH treet and number)	IAI'I	4b. City, Town,	or Location of Death	Februa	4c. County of		
2			John Hopkins Hospital 5. Social Security Number 6. Sex	7 Ago	In use last hirthday		altimore	R Date of Bir	*h 6). Birthplace (State or Foreign Country)	
5	Funeral Director			or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) $1 \square$ M $2 \square$ F 41 Yrs. Months Days Hours Min. $10-19-1964$							
	rland		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits	
	e Man	Completed by Funeral Director	MD N/A		BALTIMORI	Ξ				Yes 2□No	
	with the		740 Wharton Court			10f. Zip Code 21205			10g. Citizen of Wh United S		
	oms 23			2. Was Decedent Ev Armed Forces?	er în U.S. 13	. Was Decedent of	Hispanic Origin? (Sphan, Mexican, Puerto	pecify Yes or No)- 14. Race -	American Indian, White, etc.	
36	rs after		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2√ N		,		BLACK	
2-0	72 hou		15. Decedent's Educ (Specify only highest grade	ation	(Giv	edent's Usual Occi e kind of work don	e during most of wor	king	16b. Kind of Busin	ness/Industry	
121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show many lightly grighter traumatic event. Ire Medical Examinar must be notilized at once.		Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retii MAKER	red)		N/A		
pu	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)		
Maryland 21215-0036	hould b d Ment marked matic e	스	RAYMOND JOHNSON 19a. Informant's Name/Relationship (Type		19b. Mai	ling Address (Stree	PHELZIE			VGHAM ity or Town, State, Zip Code)	
	and 2 selth ar n 27 le		Phelzie Cunningham			_	allas Cour	t, Balt			
Jore	ges 1 a		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re			ematory or other p	2/15/	2006	20c. Location - Ci		
Baltimore,	Depermit. P. Depertment Important eny Injury once.	. 1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	θ		22. Name and Add	ress of Facility	2	Baltimor 818 E. Ba	1+imoro C+	
Ä	90 E 9	6 6	Mala Tola	M01452	Re	endon Fur	eral Home	, P.A. _B	altimore,	MD 21224	
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	V				or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician /Medical Examiner phrial-Itansit phrial-Itansit	ē	disease or condition resulting in death)		and alcohol	. intoxicat	10n				
			Sequentially list conditions, b	Due to (or as a	Due to (or as a surresqueries of):						
		Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due to (as as a second of the second of t							
,09,		Physician/Medical Ex	resulting in death) Last Due to (or as a consequence of):								
9289	certificate be nding physicie ise as the bus		IF FEMALE:								
Box	wrequires thet the death certificate be been signed by tha attending physicie should be detached for use as the bur		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	□Ectopic pregnan	су		23d. Date of Month	,	
P.O.	The law requires thet the death ate has been signed by tha atter bage 2 should be detached for u	hysi	1 □ Yes 2 □ No 9 N Unknown	9□ Unknown							
	signed d be de	Completed by P	Part II. Other significant conditions con Cocaine use	tributing to death but	not resulting in the	underlying cause g	jiven in Part I,			ute to the cause of death?	
cor	aw requ s been 2 shoul							24a. Was		re autopsy findings available	
a Re	The tcate ha	Com						auto perfo 1 🗷 Yes	prived? dea	or to completion of cause of hth? Yes 2 No	
Vita	s certifi s certifi director	o Be	25. Was case referred to medical examiner? 1 Ves 2 No	ospital:	2 XER/Outpatie	2 7 DOA C	26. Place of Dea		one) dence 6 🗆 Other	(Spaniki)	
Division of Vital Records,	ng Phy Mer thi	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. Time	/ 100 1	ury at ork?		how injury occurred		
/isio	Attand death ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	2/8/06 Fnd 28e. Place of Injury			⊒Yes 2XXVNo	unk 28f. Location (ation (Street and Number or Rural Route Number,		
- a a e a o locate at noise								Town, State) /41) Warton Court			
	Hospl 24 hou Funer stely fill	edical	29a. Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examin	er: On the basis of e and manner state	xamination and/or i	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)	
	To the To the comple	Z.	29b. Signature and title of certifier			29c. Lice	nse number	29d. Date signed (Date signed (Month, Day, Year)		
		8	Jashel	ef m		00	ME ————————————————————————————————————		Feb. 9,	2006	
			30. Name and address of person who contact a Z Green be		un (item 23a) (Type		nn Street Ba	ltimore,	Maryland 21	201	
	Sta Registi		31. Date filed (Month, Day, Year) FFB 1 3 20	32 Registrar	s Signature	orde					

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #1, 2-3-06, per Dr, Health and Mental Hygiene

Reg. No. Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Irena Day **Physician** -Irina Dobosz 1:22 p February 1, 2006 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ellicott City 3294 Kaiser Rd If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Howard Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days 1 ☐ M 2 🖺 F 165-76-2401 Yrs Director November 22, 193<u>3</u> Poland Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Poland NONE Boleslawiec Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 59-700 Poland Jana Pawea 4 B M Z permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or itama 23a any injury or other traumatic avent, the Madical Examiner measurement once. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Restuarant Elementary/Secondary (0-12) College (1-4or 5+) Chef unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jozefa Dyduch Władysław Watroba 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3294 Kaiser Rd. Ellicott City, Maryland 21043 Daughter Mrs. Ewa Golonka 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/14/06 Boleslawiec, Poland Parish Cemetery 4 □ Defilation 5 □ Other (Specify) 21. Sanat re of Fureral Service Lig 22. Name and Address of Facility Endelle Slack Funeral Home, P.A. MO0531 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) days ASCAD /Medical Due to (or as a consequence of) **Examiner** months Severe Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Uncontrolled Diabetes Mallitus months Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) daughters home P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No M investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D51586 February 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Kim, Victor Y., M.D. 6955 Oakland Mills Road, Columbia, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **FEB 03** 2006 Registrar

Physici /Medic Examir	20-	Decedent's Name (First, Middle	, Last)					 Date of Deat Month 		_ Year_	3. Time of Death
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Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Service I	De		22. Name and 1		town Pi				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Rag. No. UUS 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 28, 2006 4:57 P M 0gbonna Eaton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Route 32 @ Sanford Road Ft. Meade
If Under 1 Year If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year Oct. 5, 1 9. Birthplace (State or Foreign Country) Patterson Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F 1976 New Jersey 147-76-6374 29 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Show other than "naturel; or Items 23s or 28s-f shov vent, the Madical Examiner roust be ciptified at 1 ☐ Yes 2 XNo Directo Fairfax Virginia Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11600 Fairfax Meadow Circle Apt.16004 22030 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel; or Iter 1 X Never Married 2 Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Computer Engineer Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Sidney R. Eaton Katrina B. Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Katrina B. Seymour Mother 8131 Rainwater Circle, Manassas, Va. 20111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Stonewall Memory Gardens Department of Important: If it in eny injury or o once. 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 2/6/2006 4 ☐ Donation 5 ☐ Other (Specify) Manassas, Va. 20109 21. Signature of Funeral Service Licenses Ames Funeral Home, Inc. 22. Name and Address of Facility 8914 Quarry Rd. Manassas, Va. 20110 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** and Head nech vyuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ysicien and e burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical phys the L 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 ☐ Yes 3 Probably 4 □Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Dether (Specify) At Scene P 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation Motorgile driver = collision death. 4:53 PM 1 Yes 2 No Jan 28,2006 Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) R+ 32 at Sunford Rcd, Fr Mede, 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide malwa Fr Mede, MD 1 Certifying Physician: To the best of my knowledge, death-occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenberg M.D. 111 Penn Street Baltinore, Maryland 21201
31. Date filed (Month, Day, Year) 32 Registrar's Signature

State

Registrar

FEB 02

2006

Taylor L. Errickson Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Unpend item#1,23a,27,28a-f,perME,9855,5/2/00 TT State of Maryland / Department of Health and Mental Hygiene 06 - 1019AKG Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 9, 2006 9:44 A TAYLOR LEIGH ERRICKSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Easton Talbot Easton Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Days Hours Min. JAN 11, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 F MARYLAND 212-75-2974 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 124 CHOPTANK AVE. 21601 USA death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: WHITE à 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 0 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg. important: if Itsm 27 is marked other sny injury or other traumer: other traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN HEATHER L. ERRICKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) HEATHER L. ERRICKSON/MOTHER 124 CHOPTANK AVE., EASTON, MARYLAND 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 2/14/2006 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden unexplained death in infancy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No ō Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ⊉Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No autopsy performed? 12 Yes 2 No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 □ No 1 Inpatient 2€XER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 TNo Fnd 2/9/2006 Fnd 9:18 A 2 Accident the 6 X Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 Choptank Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Easton, MD within 24 hours a To the Funeral D Hospitai House 29a. Certifier To the cause (s) and manner as stated. Medical (Check only one) 2XI Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 10, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ANA

31. Date filed (Month, Day, Year)

RUBIO

6

MD

2006

32. Redistrar's Signature

111 Penn Street, Baltimore, Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 29 7:45 a Alice Mae Foxwell January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 😿 F Director 215-20-2090 80 1, 1925 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Evantings must be notified at 1 Yes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 813 Race St. 21613 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: white δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) trucking company secretary 11 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: If Item 27 is marked other Earl Page Jones Wilsie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Foxwell husband 813 Race St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2/2/06 Maryland Veterans Cem. Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Lie nsee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERIOSCLEROTIC /Medical Due to (or as a consequence of): Examiner Cances Securality list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of s a consequence of): Examine burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 🗆 No 1 Yes 2¥ No 1 TYes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 XInpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 🗌 Pending death. 1 Tes 2 No investigation 2 Accident vithin 24 hours after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Makhter 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge M 21613 2006 Nagarar's Signature 31. Date filed (Month, Day, Year) State 3 Registrar

Funeral Director

	1 - For State Registra AMEND#10a/boerFF	State of Maryland		artment of		Mental Hy	201	16	01.5	ΊΩ
	Registrary FIV # 10d/ OPERF 1. Decedent's Name (First, Middle, Last)	12/2/00, BYW, PDCO		incate of	Douth	2. Date of De		UU	3. Time of	Death
an al	Florentino Serrano	Gorospe, Sr.				Januar	y 30, 2	2006	7:48	РМ
r	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Deat	h		nty of Death		
	Shady Grove Advent	ist Hospital		Rockvi			Montg	gomery		
	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Days		(Month, Da	ı <i>y, Year)</i>	Cou	place (State o	
-	732-01-1009 Usual Residence of Decedent		113.			0ct. 3	0, 1919	Phil	ippine	S
	10a. State 10b. County None	10c. City	, Town or Lo	cation					10d. Inside Cit	ly Limits
	N/A	Beng	guet P	rovince,	Baguio (City			1 ▼ Yes	2 🗆 No
Ì	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	14 Ambuklao Road			2600			Philip	pines		
	11. Marital Status	Was Decedent Ever in U.S Armed Forces?		Vas Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)		ace - Ameri lack, White		
	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🔯 No If Yes, Give		l □ Yes 2 ☑ No		, , , ,		ity: Fil:		
	3 Widowed 4 Divorced	Year or Dates:								
į	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occi kind of work don DO NOT use retir	e during most of wo	rkıng	16b. Kind of Philip		ndustry	
1	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			50)		Govern	-		
ŀ	17. Father's Name (First, Middle, Last)		Attor	цеу	18. Mother's Na	me (First, Middle				
l	Valeriano Gorospe				Petra S			,		
-	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	a Address (Stree	at and Number or Ri	ural Route Numb	er. Citv or Tow	m. State. Zii	code)	
1	Corazon Andrada/ Da				Drive, Ga				100	
	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of		Date	20c. Location	n - City or T	own, State	
	1 Burial 2 Cremation 3 Re	amoval from State M	etropo		ICDI	uary 3,	Alexa			
}	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			um, Inc				irgin	ia	
	1 Signature of the contract of				ess of Facility De				MIL O	007
	23a. Part /E fer the disease, or complic	MQ0689						spurg	Approximate	
	> of kill or heart failure. List only on	e cause on each line.	. Do not ent	ar the mode or dy	ing, such as cardia	c or respiratory a	rrest,		Interval Bety Onset and D	₩een
	Immediate Cause (Final disease or condition resulting in death)	Congestive H	leart 1	Failure					years	
	resulting in death)	Due to (or as a consequ	•							
	Sequentially list conditions, b	Coronary Art		Lsease					years	
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or).							
	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
		200 (0) 23 2 0013042	ionos or).							
	d									
	IF FEMALE:	3c. If yes, outcome of pregnar	nev				204.5		500	
	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnan	су			Date of deliv Month		ear /
	1 Yes 2 No	4□Pregnant at time of de 9□ Unknown	iatn 5∟	Other (specify)					ľ	
	Part II. Other significant conditions con-	tabuting to death but not recu	Iting in the w	adorhina cauca c	mon in Part I	23a Did I	obacco use co	ntributo to 1	he cause of d	oath?
•	Hyperlipidemia	thoung to beat but not resu	iking in the di	raeriying cause g	IValiant ait.		Yes 21€ No		bably 4 □U	
	пурсттрисшта					,	103 2,2,140	30,110	outly +c	
1						24a. Was	DSV	prior to co	opsy findings a	availabl
1						perfo 1 ☐ Yes	rmed? 2 5 No	death?	2 No	
1	25. Was case referred to medical examiner?	2/4			26. Place of De	ath Check only	оле			
	1 ☐ Yes 2 🛣 No		ER/Outpatien	t 3 DOA	ther: 4 Nursing H	iome 5 ☐ Resi	dence 6 🗆 0	ther (Speci	fy)	
l	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj. W	ury at ork?	28d. Describe	how injury occ	urred		
١	2 Accident investigation]Yes 2□No					
ı	3 ☐ Suicide -6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	9	28f. Location (City or To		mber or Rur	al Route Num	ber,
ļ										
1	29a Certifier X Certifying Physics (Check only 2 Medical Examin	ician. To the best of my knowner: On the basis of examinat	wiedge, death	section in my	time, date and place	s, and due to the	date and place	name at at	tuted.)
	one)	and manner stated.								
1	29b. Signature and title of certifier	VI.	1 -		nse number		29d. Date sign			
	Saima	Khawa	1-	D58	965		Januar	y 31,	2006	
1	30. Name and address of person who cor	mpleted cause of death (It im	23а) (Туре,	Print)						
	Salima Khawaja, M.	D., 11119 Roc	kville	e Pike,	#100, Roc	kville,	MD 208	52		
	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	0 A B 2						
	FEB 0 2 20	32 Registrar's Signat	F AND	Sept Sept Sept Sept Sept Sept Sept Sept						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of	Maryland / De	partmen ertificate				_	giene Reg. No.	06	045	79
Dhysis	ian	1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath Day	Yea	3. Time	of Death
Physic /Med		Sarah Eliza	beth G	lover					Januar		2006		р м
Exam		4a. Facility Name (If not institution,	give street and numb	ber)	4b. City,	Town, or	Location of	of Death		4c. C	ounty of De	ath	
		Holy Cross Hosp					Spri				lontgo	mery	
Funera		,	i. Sex 7 1 ☐ M 2 🖸 F	. Age (In yrs. last birtho	Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da May 25	th y, Year)		Birthplace (State Country)	
Directo		Usual Residence of Decedent		81 Yrs			l		May 25	, 192	4 Mi	ssíssip	pi
land ow		10a. State 10b. County		10c. City, Town o	r Location							10d. Inside	City Limits
Mary -f sh	ţō	Maryland Montgo	merv	Rockv	i11e							1 ⊠Ye	s 2 No
r 288	irec	10e. Street and Number		ROCK	10f. Zip	Code				10g. Citize	on of What	Country?	
h witi 23a o	Funeral Director	729 Monroe Stree	t #204		20	850				USA			
deat	ner	11. Marital Status		lent Ever in U.S.			ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)			merican Indian,	
after or Its		1 Never Married 2 Marrie		? ⊠No	1 ☐ Yes 2				rican, etc.)		Black, WI		
5-0036 72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dieal Examinar must be notified at	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dat	es:	10,163	. 25110	эроспу.				Cau	casian	
15-172 in 172 in	Completed	15. Decedent's (Specify only highest		16a. D	ecedent's Usua live kind of wor le. DO NOT us	l Occupa k done d	ation during mos	t of worki	ng	16b. Kind	d of Busines	ss/Industry	
withir than	m	Elementary/Secondary (0-12)	College (1-4	4or 5+)			7			M - 4	4 1		
filed Hygie than	ပိ	17. Father's Name (First, Middle, La			Physici	an	18. Mothe	ar's Name	(First, Middle,		ical		
d be and o	00	Elder Glover							eene-G1		amamo,		
Maryland 21215-0036 nd 2 should be filed within 72 hours att lith and Mental Hyllene. 27 is marked other than "natural", or reaumatic event, the Medical Exemit traumatic event, the Medical Exemit	T ₀	19a. Informant's Name/Relationship	o (Type, Print)	19b. M	ailing Address	(Street a			l Route Numbe		Town, State	a, Zip Code)	
Md 2 alth a 27 is	1	Stephanie Nourse	/ Executo						la, Mar				
of Hee		20a. Method of Disposition		20b. Place of D					ate			or Town, State	
Bage and		1 ☐ Burial 2 🔀 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		Ft. Lin			- 1	02/03	3/2006	Bre	ntwoo	d. MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show any injuryor phar traumatic evant, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Li	censee									Center	
O		Mas	p		1040 Ro	ckvi	lle I	Pike	Rockv	ille,	MD 2	0852	
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	inplications that cally one cause on each	used the death. Do not ch line.	enter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
Physician		Immediate Cause (Final disease or condition	Ruptur	ed Abdomin	al Aort	ic A	neury	ysm				Onset and	1 Death
/Medical Examiner		resulting in death)		r as a consequence of)			-	Sec					
LAUMINIC		Sequentially list conditions,	_{b.} Abdomi	nal Aortic	Aneury	sm						Unkno	wn
ted sit	njue	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury	5691010	r as a consequence or									
sxecu and	Examine	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of)								-	
18760, cate be executed physician and the burial-transit			d										
687 tiflicate g phys	Physiclan/Medical		· ·										
Box 68 leath certifics attending pl	J/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 D Fetal death	3 □Ectopic pr					23	ld. Date of c	delivery	
. 0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No		nt at time of death	5 Other (sp						Month	Day	Year
ords, P.O. requires that the de	Phy	9 Unknown											
0 8 8 8 B	5	Part II. Other significant condition	s contributing to dea	ith but not resulting in th	e underlying c	ause grve	en i n Part I.	•				to the cause of	
cord w require been sig	Completed						-		101	Yes 2	No 3	Probably 4 5	Unknown
Rec The taw Ite has b	nple								24a. Was autor	osy	prior t	autopsy finding o completion of	s available cause of
Vital Re ician: The ti certificate ha										rmed? 2⊠ No	death 1 🗌 Y		
of Vital Record Physician: The law requir this certificate has been si	o Be	25. Was case referred to medical examiner?	Hospital:			. Othe	200		(Check only o				
	I	1 Yes 2 No 27. Manner of Death	28a. Date of	patient 2 ER/Outpa		A	4 🗆 140		ne 5 Resident			pecify)	
Vision Attending r death. actor: After	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	(Month,	, Day Year) Inju	ry M	8c. Injury Work	<br Yes 2 ☐ I			,,			
Division or Attending after death. Diractor: Afte	ertification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of	f Injury - At home, farm	street, factory	, office		- :			Number or	Rural Route Nu	mber,
Division of the points after deat and Diractor: filled in by the	Cert	4 Homicide	building	g, etc. (Specify)					City or Tov	wn, State)			
Hospital of the same of the sa	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the b	est of my knowledge, ones of examination and/o	eath occurred	at the tim	ne, date an	d place, a	and due to the	cause(s) a	nd manner	as stated.	(e)
To tha Hos within 24 h To tha Fur completely	Medi	one)	and manne	er stated.									(5)
To To	-	29b. Signature and title of certifier	L V.	2 + 10	7 .		number					onth, Day, Year)	
5		20 11 11 11		on 1 la		1 48	78	0		Janu	ary 2	9, 2006	
		30. Name and address of person w				D	1. 2.	. 1	. C		0001	0	
S	tate	Hugh H. Trout I 31. Date filed (Month, Day, Year)				Roa	u; 51	ııver	Spring	g, MD	2091	U	
Regis		FEB 02	2006	gistrar's Signature	greets)								

			1 - State Amend Ite	State of Maryland / Department of Health and Mental Hygiene 23a per Dr., G852-02-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6-6	04580
	Physici /Medio		1. Decedent's Name (First, Middle, Last LOUISE BOWD	DLE GRAY 2. Date of Death Day Day D- 01-200	3. Time of Death
1	Examir	er	4a. Facility Name (If not institution, give WILLIAM HILL	MANOR EASTON TALK	BOT
	Funeral Director		5. Social Security Number 6. Se 218-10-0314 11 Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9.	Birthplace (State or Foreign Country)
	Maryland I-f show	tor	10a. State 10b. County	LINE FEDERALSBURG	10d. Inside City Limits 1
	h with the 23a or 28s	Funeral Director	10e. Street and Number 322 MAPLE	AVENUE 10f. Zip Code 10g. Citizen of What 21632 USA	Country?
336	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jical Executions te notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		merican Indian, thite, etc.
1215-0036	within 72 hou iene. 'than "nature I've Medicul E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation 16b. Kind of Busine 16b. Ki	7CS
Maryland 21	tould be filed to Mental Hygie harked other inatic event, It	To Be Co	17. Father's Name (First, Middle, Last) CLARENCE	BOWDLE 18. Mother's Name (First, Middle, Maiden Surname) MARY ETHEL RO	SS
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 23s-1 show any Injury or other traumatic event, the Medical Exprince from the Indianal Exprince from the Indianal Expression of the Indianal Expression		19a. Informant's Name/Relationship (7) BARBARA SMITH 20a. Method of Disposition	DAUGHTER 419 ACADEMY AVENUE FEDERALS 20b. Place of Disposition (Name of Date) 20c. Location - City	BIRG 21632
Baltimore,	permit. Page Department of Important: If any Injury or once.		1	BLOOMBRY CEMETRY 4/03/06 FEVER-	USBURG, MD
B	permit. Departr Imports any Inj		23a. Part1. Enter the disease, or comp.	Dilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	MD 21632
	Physician		shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.	Approximate Interval Between Onset and Death
3			disease or condition	a Cardio Respiratory Arrest	Minutes
	/Medical Examiner	lner	resulting in death) Sequential y list conditions of any, leading to immediate	Due to (or as a consequence of): b. Brain Stem Infarction Due to (or as a consequence of):	Minutes 1 day
760,	/Medical Examiner	cal Examiner	resulting in death) Sequentially list conditions.	Due to (or as a consequence of): b. Brain Stem Infarction	
.O. Box 68760,	/Medical Examiner	cal	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Brain Stem Infarction Due to (or as a consequence or): c. Cerebrovascular Disease	1 day 10 years
P.O. Box 6	/Medical Examiner	by Physician/Medical	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence of): b. Brain Stem Infarction Due to (or as a consequence or): c. Cerebrovascular Disease Due to (or as a consequence of): d	1 day 10 years delivery Day Year
Records, P.O. Box 6	The law requires that the death certificate be executed at the bean signed by the attending physician and page 2 should be detached for use as the buriat-transit	by Physician/Medical	resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22No 9 Unknown Part II. Other significant conditions co	Due to (or as a consequence of): b. Brain Stem Infarction Due to (or as a consequence or): c. Cerebrovascular Disease Due to (or as a consequence of): d	1 day 10 years delivery Day Year so to the cause of death? Probably 4Unknown autopsy findings available to completion of cause of its
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			Registrar 1. Decedent's Name (First, Middle, Last)	Trimodio or Dodin	2. Date of Death	ı. No.	3. Time of Death
	Physici		Arthur E. Goguen		Jan. 30	Day 2006 Year	8:15 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Examin	iei	William Hill Manor	Easton		Talbot	
т	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birthp	lace (State or Foreign
l.	Director		018-03-2480		March 22	2, 1912 Ma	ine
	n 72 hours after death with the Maryland "natural, or items 23a or 28a-f show ledical Examinat must be mullified at	tor	10a. State 10b. County 10c. City, Town or Maryland Talbot	Location Easton		1	0d. Inside City Limits 1 ∰Yes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	itry?
)	23a		7306 Frances St.	21601		U	ISA
		Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Amend Black, White,	
9	s afte	by Fi	1 Never Married 2 Married 1 Tes 2 No If Yes, Give 93 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: 571	
9500-c	within 72 hours after ene. than "natural", or ite re Medical Exemina	o p		adant's Heual Occupation	14	WIT 6b. Kind of Business/Inc	ite
Ċ	n 72	jete	(Specify only highest grade completed)	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ing	D. Kind of Dusinessynn	Justry
7	with thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	insurance Sales		Insur	ance
ס ס	filed Hygi other ent.	ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
and		To Be	Fred Goguen	A1	ice Richa	ard	
2	should but Ments markad	-		iling Address (Street and Number or Rur			Code)
Z Z	and 2 ealth a n 27 is		Carol Keen/Daughter 730	6 Frances St., Eas	ton, MD	21601	
ā,	- I = I				· · · · · · · · · · · · · · · · · · ·	c. Location - City or To	wn, State
Baltimor	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Fremation 3 Removal from State 1 Donation 5 Other (Specify)	CremationCenter 1/	31/2006	Cambridge,	MD
	artm artm ortar injur						
ñ	Departing Department on in once.	1	blee texas Derringer	22 Name and Address of Facility fid Shore Cremation 2272 Hudson Rd., Ca	mbridge	P.U. BOX 1	.464,
		X	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate
ı,			Immediate Cause (Final	Don O Faller	0		Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	range raceur	(4	- week
	Examiner		End	(tope Renel	Misen	7	742
		ē	if any, leading to immediate Due to (or as a consequence of):	71-90			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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Q Q	the death certifica y the attending ph iched for use as th	Medi	Tresume.			7	
ŏ	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	B Ectopic pregnancy		23d. Date of delive	*
ם מ	dea death	sicia	1 Yes 2 No	Other (specify)		Month	Day Year
r Ö	that the de led by the a detached f	h.	9 🗆 Onknown				
cords, 1	The law requires that tte has been signed b page 2 should be deta	b	Part II. Other significant conditions of himbuting to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the 2 No 3 □ Prob	ably 4 Unknown
ပ္ပ	s bee	Completed	ASH) will Concerting Heart	Failure	24a. Was an	24b. Were auto	psy findings available
Ä	The la	E O	Ciapulandia O Reflect i	200-0	autopsy performe	ed? death?	inpletion of cause of
		O	25. Was c se referred to medical	26. Place of Deat	h (Check only one)	37.0	20,10
	> 0 0	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Othor		ce 6 ☐Other (Specif	v)
וסו	Attanding Physiclan: r death. actor: After this certific by the funeral director,	n: T	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injur		28d. Describe how	injury occurred	
0	ath. ar: Af	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
_	To the Hospital or Attanding Ph within 24 hours eliter death. To the Funarel Director: Affer th completely filled in by the funeral		29a. Certifier 17 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cau	ise(s) and manner as s	ated.
	ha H in 24 ha Ft pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	mivestigation, in my opinion, death occur			
	To t To t	Σ	29b. Signature and title of ⇒rtifier	29c. License number	290	d. Date signed (Month,	Day, Year)
			· William Hood Jul	DE8715		1/31/06	,
			30. Name and address of person who completed cause of death (rem 23a) (Tyr. William H. Wood, Jr., M.D., 501 Du	e. Print) tchmans Lane. Easto	on, MD 2	1601	
	- 64	10		,			
	Sta Registr			Anask.			

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of ertificate o			giene Regino 06	04582
Physic	ian	Decedent's Name (First, Middle					2. Date of De Month	Day Year	3. Time of Death
/Medi		ROBERT 4a. Facility Name (If not institution	BERGMANN	HOTZ	4h City Town	, or Location of Dea	FEBRUAI	RY 9, 2006 4c. County of Dea	2:25P M
Exami	ner	FREDERICK MEMO			FREDEF			FREDERI	
Funeral Director		5. Social Security Number 398–09–7488	6. Sex 7. A(1) X 1 M 2 □ F	ge (In yrs. last birthday 91 Yrs.) II Under 1 Yea Months Day		n. (Month, Da	ay, Year) C	thplace (State or Foreigr ountry) SCONSIN
e Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frede	erick	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🎇 No
ad within 72 hours after death with the Maryland gliene. Is than "natural", or flame 23a or 28a-f show. It the Madical Expressive to the Denvilled at	ed by Funeral Director	9702 Mt. Tabor 11. Marital Status 1 Never Married 2 Maria Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 XYes 2	WWII		773 Il Hispanic Origin? (Juban, Mexican, Pue Ilo <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	0	ntes encan Indian, le, etc.
within 72 ene. than "na	Completed	(Specify only highe Elementary/Secondary (0·12) 12	st grade completed) College (1-4or	5+) (Give	e kind of work dor DO NOT use reti	ne during most of w ired)	orking		·
be fill tal H d oth	To Be Co	17. Father's Name (First, Middle, Harry Hotz	Last)	J	ournalis	18. Mother's Na	ame (First, Middle, Bergmann	Publishin , Maiden Sumame)	<u> </u>
s 1 ar	L	19a. Informant's Name/Relations Joan W. Hotz / 20a. Method of Disposition 1 □ Burial 2 ☑Cremation	wife	9702 20b. Place of Disp cemetery, cre	Mt. Tab	or Rd., N	yersvill Date	20c. Location - City or	73 Town, State
permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (S 21. Signature of Funeral Service		_ 2	22. Name and Add	torium 2, dress of Facility Funeral I	Р.	Smithsburg O. Box 136 yersville,	, 504 Main
Physician / Medical Examiner as the prival-transit	ilcal Examiner	23a. Part1. Enter the disease, or shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence of): a consequence of): a consequence of):		ying, such as cardi		irest,	Approximate Interval Between Onset and Death Z (C)
ath certific titending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of de Month	livery Day Year
i or Attending Physician: The law requires that the deather death. Director: After this certificate has been signed by the a fin by the funeral director, page 2 should be detached it in by the funeral director, page 2.	þ	Part II. Other significant condition	ons contributing to death t	ce Mac	~ t			tobacco use contribute to Yes 2 No 3 P	o the cause of death?
The ate h page	Completed	T5/06d	y & phe	unil e	ffysi	~	24a. Was autoj perfo 1 🗆 Yes		utopsy findings available completion of cause of
ding Phys n. After this funeral di	atlon: To Be	25. Was case relerred to medica examiner? 1 Yes 2	gation	rv 28b. Time	ol 28c. In	Other: 4 Nursing		one) dence 6 □Other (Spe how injury occurred	icity)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of in building, e	jury · At home, larm, sic. (Specify)			City or To		
the Hospital nin 24 hours the Funeral npletely filled	edical	(Check only 2 Medical one)	ng Physicien: To the best Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my	y opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To T To T	M	29b. Signature and title of certifie	Burn	•	29c. Lice	onse number	9	29d. Date signed (Mont	th, Day, Year)
8		30 Name and address of person AUSTA A Rear	who completed cause of a 300 M	death (Item 23a) (Type		erick, M	D 217	01	~ ()
St Regist	ate rar	31. Date liled (Month, Day, Year) FEB 1 6	2006 33 Regist	rar's Signature	and a				

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment artificate					ene g: No.	6	0458	3
	Dhyciai	on.	1. Decedent's Name (First, Middle, Last)			_			2.	Date of Death		Year	3. Time of	Death
	Physici /Media		Richard George Ha								31, 200	06	11:07	'A ^M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City,		Location			4c. County			
	Funeral		2334 Putnam Lane 5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday) If Under		ofton		Date of Birth			undel place (State or	r Foreian
	Director		060-22-7116 ¹ ☑	M 2□F	75 Yrs.	Months	Days	Hours	Min.	(Month, Day, 20. 17,	1930	Cou	falo, N	
	pun		Usual Residence of Decedent 10a. State 10b. County		10c. City. Town or L	castica							10d. Inside Cit	
	Aaryla f sho	ō	Maryland Anne Aru	ndel	,	ofton							1√2 Yes	•
	the t	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	What Cou	intry?	
	h with	ai Di	2334 Putnam Lane				2	21114			USA		ĺ	
	ems a	iner	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deced	lent of Hi	ispanic Ori	gin? (Specif	y Yes or No- an, etc.)		e - Ameri	ican Indian,	
36	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show the Modical Exertirer must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ ! If Yes, Give	No ARMY	1 ☐ Yes 2		Specify:		,	Specify		nite	
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212	nin 72 na "na Medic	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Giv	o kind of wor DO NOT us	rk done d se retired	during mos. !)	t of working		OD. TRING OF DE	73111033/11	idustry	
7	giene giene er the	Completed	Lionomary, 3000mary (5 12)	1 yr.	Ur	dergr	ound	Line	eman		I	PEPCC)	
nd	be file	Be	17. Father's Name (First, Middle, Last) Edward Haselbaue	or				18. Mothe		irst, Middle, M		ю)		
3	12 should be filed within n and Mental Hygiene. 7 is marked other then "reumatic event, the Mes	2	19a. Informant's Name/Relationship (Typ		10h Mai	in a Address	(Ctan at a	and Alicenter		ha Lic		C4-4- 7	- 0- 4-)	
S	and 2 s ealth an n 27 is i			Daughte:						con, MD			p C00 0	
re,	f Hea item other		20a. Method of Disposition		20b. Place of Disp	osition (Nan	ne of	a)	Date	2	0c. Location -	City or To	own, State	
E	Pages nent of I ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	MD Veter				'eb. 3	, 2006	Crowns	∕ill∈	e, MD	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28e-1 show eny injury or other treumatic event, II a Medical Examinet must be notified at Once.		21. Signature of Funeral Service License	A Br	alton	2. Name an			pea1	l Fune: Sowie, 1				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused	the death. Do not en							13	Approximate Interval Betw	veen
	Pnysician ·		Immediate Cause (Final disease or condition	Corono	ry artin	u (1	10	are					Onset and D	eath
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o.	that the de led by the a detached t	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	unio or additi		JUNY)							
ر. ح	es that igned b	by PI	Part II. Other significant conditions cont	ributing to death b	ut not resulting in the	underlying ca	ause give	en in Part 1.		23e. Did toba	acco use conti	ribute to ti	he cause of de	eath?
Records,	w require been sig should b	ed t	Anemia							1 ☐ Yes	3 2 □ No	3 ☐ Prot	bably 4 💯 U	nknown
ecc	law reas be	Completed	-							24a. Was an autopsy	24b. \	Nere auto	opsy findings a impletion of ca	variable use of
	: The	Con								perform 1 ☐ Yes 2	egi? c	death? I □ Yes	2 5 0No	
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ō	Attending Physicien: The st death. sctor: After this certificate his by the funeral director, page	٦: To	1 Yes 2 Solo	28a. Date of Injur	nt 2 ER/Outpatie		Bc. Injury	at at		5 Resider			fy)	
ion	nding ath. r: Afte e fun	atio	T Natural 5 Pending 2 Accident investigation	(Month, Da)	Year) Injury	М	Work	<br Yes 2 🔲 !	No					
Division of	or Attendater deatl	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home, farm, s	reet, factory	, office		28f	Location (Streetile City or Town,	et and Numb	er or Rura	al Route Numb	er,
	itel or A	O												
	To the Hospitel or within 24 hours afte To the Funerel Dire completely filled in b	Medical	29a. Certifier (Check only one) 2 Medical Examin	er: On the basis of and manner sta	examination and/or in	th occurred anvestigation.	at the tim in my op	ne, date an pinion, dea	d place, and th occurred	due to the car at the time, da	use(s) and ma te and place, a	nner as s and due to	stated. o the cause(s)	
	To the within 3	Σ	29b. Signature and title of certifier			29c	License	number	· C.	29	d. Date signed	1 (Month,	Day, Year)	
2	(10)		- Sull				158	575	5		131	16		
_	(10)		30. Name and address of person who cor	npleted cause of d	(Item 23a) (Type	Print)	И.	1	0	v ali	P.	espotar i	4444	1061
	Sta	te	31. Date filed (Month, Day, Year)	Registra	ar's Signature	ram	TICS	thea	9 3 1	n ale	N DUX	nu	MIDY	1001
	Registr		PEB 0 2 2008	Been	ar's Signature	de	\	V						

State of Maryland / Department of Health and Mental Hygiepe 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 209 Month **Physician** HARRIS MARY Ο. Johnar d006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 12, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Days Hours 1 M 2 TF 80 Henderson, NC Director 578-34-9639 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at MD Prince Georges Landover 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20785 U.S.A. 7715 Oxman Road items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) P.G. Hospital Laundry Supv. 6 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any linjury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sussie Alston Donald Arthur Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Joyceton WAy Upper Marlboro, MD. 20774 Denise H.Harris-Daughter Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Harmony Mem. Park 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb.3,06 Landover, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Jugensee 22. Name and Address of Facility Hunt Funeral Home MANUS 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Fatal Arrhythmia /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarc HOUIS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Coronary Artery Disease years burial-tran and Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical the the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Ischemic Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown iis certificate has been s director, page 2 should. Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Diabetes Mellitus 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Division Injury 1 X Natural 5 Pending within 24 hours after deeth. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation М 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD 58976 Jan 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7202 Quisin Berry WAy, Bowie, MD. 20720 Vima Calaf, M.D. 31. Date filed (Month, Day, Year) 3. Registrar's Signature State FEB 0 2 2006 Registrar

			1 - For State Registrar AMEND#23a(b)pe	State of N	Maryland	d / Depa	artmen	t of H	ealth a Death	and Me		giene Reg. No.	006	04585
£5.	. T. P.		1. Decedent's Name (First, Middle, Las		<u> </u>	<u> </u>					2. Date of Dea		Va	3. Time of Death
	Physici /Medic		Setsuko Havens								Januar		Yea , 200	3.4
1	Examin		4a. Fecility Name (If not institution, give						Location o	f Death		4c.	County of De	eath
		A.T	Shady Grove Adve					Ckvi.	L1e If Under 2	DA Hrs 6	3. Date of Birt		lontgo	
2	Funeral Director			_M 21€ F	Age (In yrs. la 71	Yrs.	Months	Days	Hours	Min. Oc	(Month, Da	Year)	934 S	Birthplace (State or Foreign Country) Outh Korea
	D		Usual Residence of Decedent											
	arylar ehow	-	10a. State 10b. County			, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	28a-1	Director	Maryland Montgom 10e. Street and Number	ery	R	lockvil	LIE	Codo				10a Citis	en ol What	
	3a or		5515 Amesfield Co	urt				0853				rog. Oniz	USA	Country
	ma 2:	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	S. 13.	Was Deced	ent of His	panic Orig	gin? (Spec	ify Yes or No	- 1	4. Race - A	merican Indian,
9	or Its	Fu	1 ☐ Never Married 2 Married	1 Tes 2	¾ No		fYes, spec 1 ☐ Yes 2		Specify:	, ruello n	ican, etc.)		Black, W Specify: A	
Ö	within 72 hours after death with the Maryland ene. than "returel", or Itema 23a or 28a-1 ehow tha Madical Exertine must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates	s:	16a. Dece	dent's Heur	I Occupa	tion				d of Busine	
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212	d with giene	mo:	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Home	emakeı	r					Own 1	Home
p	al Hy	Be	17. Father's Name (First, Middle, Last) Akiyoshi Watanab								First, Middle,		Sumame)	
yla	ould to	ို	,								ashige			
, Maryland 21215-0036	and 2 sh aith and 27 is m or traum		19a. Informant's Name/Relationship (7 Loria Edmund Hav		band						Route Numbe			a, Zip Code) and 20853
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "neturel", or Itema 23a or 28a-1 show mortant: if Item 27 is merked other than "neturel", or Itema 23a or 28a-1 show eny injury or other traumatic event, the Macinal Enarchment be rediffied at ODGE.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te ce	lace of Dispo emetery, crer ropolita	natory or of	ther place)	Da Janua 20	ry 30,			or Town, State
Balti	permit. Departr Importa eny inju		21. Signature of Funeral Service Licen	See A		F1 50	name and Cancis O Uni	d Address J. Lvers	collisity	ins F Blvd,	uneral W, Si			
3			23a. Part1. Enter the disease or composition of the shock, or heart lailure. List only	olications that caus	sed the death									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Septic										Onset and Death 1/26/2006
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ience of):								1/26/2006
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	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.										
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687	the the	edical		. d.										
Вох	death certific: e attending pl id for use as t	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre					2	3d. Date of	delivery
O. B	0 0 0	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant 9☐Unknown	at time of de		Other (sp						Month	Day Year
<u>Ч</u>	that the detected	Physi	Part II. Other significant conditions or	ontributing to death	hut not resu	ulting in the u	nderhina c	auca awa	n in Dart I		23e Did to	phacco us	e contribute	to the cause of death?
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Ö	s been si should	Completed								_	24a. Was	an	24b. Were	autopsy findings available
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<u>ta</u>		He C	25. Was case referred to medical examiner?	4180 111-1-100 1-					26. Place	of Death	Check only o	-		00 22.10
<u>></u>	등 요금	To	1 ☐ Yes 2 Ã No	Hospital: 1 Inpa		ER/Outpatien		1	4 🗀 1401	rsing Homi	e 5 ☐ Resid	dence 6	□Other (S	pecify)
nc	ding P h. After t tunera	ion:	27. Manner of Death 1 ™atural 5 □ Pending		Day Year)	28b. Time of Injury	M 2	8c. Injury Work			ld. Describe h	ow injury	occurred	
Division of Vital Record	deat deat ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		Injury - At hor	me, larm, str			es 2 🗆 N		II. Location (S	Street and	Number or	Rural Route Number,
<u>S</u>	i Dit	Certification:	4 Homicide	building,	etc. (Specify	7)	201, 120,019	,			City or Tou	vn, State)		
	Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho H	edical	29a. Certifier (Check only one) 1 XXCertifying Ph 2 Medical Exam	ysician: To the be- niner: On the basis and manner	of examinati	wiedge, death ion and/or in	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, ar th occurred	d due to the d at the time,	cause(s) date and	and manner place, and c	as stated. fue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License						onth, Day, Year)
)	Q		1					D58	681			J	anuary	27, 2006
	0		30. Name an addre s if person who o					De: 1) 1			2054	
O.S.	Sta	te.	Jude Alexander, 31. Date filed (Month, Day, Year)						ve, h	COCKV	ille,	MD 20	J850	
1	Registr		FEB 0 2 2	006	strar's Signat	The Age	SALA.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 5:42 а м January 31, 2006 Florence Kathleen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Aug. 20, 1914 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔼 F Pennsylvania 277-28-1182 91 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 805 Patton Drive 20901 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ 3 Widowed 4 Noivorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Executive Secretary Religious Organization traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 is marked off James Monroe Irwin Lola Ann McMillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie A. Poland/ Daughter 805 Patton Drive, Silver Spring, MD 20901 February 3, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. George Washington Cemetery 2006 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Francis J Colfins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Upper Gastrointestinal Bleed 30 Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for it in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus Type II, Hypothyroid, Osteoporosis 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2√ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 FR/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D03835 February 2, 2006 onne 30. Name and address of person who completed cause of death ([tem 23a) (Type, Print)
David Cromwell, M.D. 831 University Blvd, E, Silver Spring, MD 20903 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 2 State 2006 Registrar

Errol G. Heron Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00822 1- State Amend item#20a, perff, 8855, 3/18/1 Department of Health and Mental Hygiene CTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Errol Garth Heron 4:14 P M February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 14009 Barkham Court Prince George's Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 9,1950 Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) Days Months Hours Min. 1**∑**M 2□F 55 111-46-6925 Yrs. Jamaića, W. Indies Director Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at Maryland Prince George's Laurel 1 ☐ Yes 2 No Completed by Funeral Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 14009 Barkham Court 20707 Jamaica 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Black If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) olth and Mental Hygiene.
27 is marked other then "I College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Heelth and Mental H filem 27 is marked off rother traumatic even Be ဥ Noel George Heron Blackwood Norma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesleyann Samuel -fiancee 14009 Barkham Court Laurel, Maryland 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Peges 1 1 Burial 2 Cromation 3 Removal from State 4 Donation 5 Other (Specify) = 5 permit. Pege Depertment of Important: If eny injury or once. St. Johns Episcopal Ch. Cametery 2/10/2006 Beltsville, Maryland 21. Signature of Funeral Service License Donald Borgwardt Funeral Home, Vorsel PA4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Sclerosis /Medical Due to (or as a consequence ot): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760 use as the ettending p IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. sete hes been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2□ No 1 Yes 2 No or Attending Physicien: after death.

Director: After this certification by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Scene 1√XYes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli within 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 203Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 Registrar 6 2003

Unpend item#23a-b, 27, perME, 9853,3/20/06 TI State of Maryland / Department of Health and Mental Hygiene () () 5 Anita L. House 06-1028 0 4588 ١KG 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** House Anita Lynn February 9, 2006 5:28 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7891 West Hills Drive Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Ap (1271), 22, 1966 7. Age (In yrs. last birthday) 39 Yrs. 9. Birthplace (State or Foreign CourMaryland 5. Social Security Number **Funeral** 220-54-4167 1 ☐ M 2 🂢 F Director Usual Residence of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at Frederick 1 TXYes 2 □ No Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 U.S.A. 7891 West Hills Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant other 7 is marked othe treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Ronald Lee House Karole Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 is
eny injury or other treu 9639 Hamburg Road, Frederick, Maryland 21702 Ronald Lee House/Father Baltimore. Method of Disposition | 20b. Place of Disposition (Name of | Date | 1 Burial 2 Cremation 3 Removal from State | 1 ths Durger Crematics | Feb. 12, 2006 20c. Location - City or Town, State
Smithsburg, Maryland 20a. Method of Disposition 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Na}Keeney and Basford Funeral Home M00021 Lun 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Subarachnoid hemorrhage /Medical Due to (or as a consequence of) Examiner Rupture of Berry Aneurysm Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sail director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No autopsy performed? 2 No 1 Yes or Attending Physician: after death.

Director: After this certific

in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_4 \square$ Nursing Home $_5 \square$ Residence $_{5} \square$ Other (Specify) at SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYes 2 ☐ No 28a. Dafe of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

30. Name and address of person

31. Date filed (Month, Day, Year)

1

6

2006

29c. License number

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 10, 2006

and manner stated.

use of death (Item 23a) (Type, Print)

32. Registrar's Signature

	•	For State Registrer	State o	f Marylan		artment of F		Mental Hyg	iene _{eg. Nö.})	06	045	89
		1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat			3. Time of	f Death
Physician (Martine)		Juanita	Moler			Johnso	n	Februar	Day	2006	7:55	5 PM
/Medica Examine		4a. Facility Name (If not institution	n, give street and nur	nber)			r Location of Dea			unty of Death		
LAGITITIO	•	Berlin Rehabili	tion Cent	er		Berlin			Word	cester		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		9. Birthpl	lace (State o	or Foreian
Director		220-58-2798	1□M 2∏F	86	Yrs.	Months Days	Hours Min	Oct. 2,	1910	Coun	vy) Virgi	-
	1	Usual Residence of Decedent				1		0000	1717	West	VILET	TiTa
Mo t		10a. State 10b. County		10c. Cit	y, Town or L	ocation				10	0d. Inside Ci	ity Limits
tal Hygiene. Ital Hygiene. d other than "natural", or items 23a or 28e-f ehow event, the Madical Examiner must be notified at	ខ្ល	MD Washi	ngton	н	lagerst	OWB					1 ☐ Yes	2 🗆 No
or 28e-f el	e	10e. Street and Number	0		GGCLDC	10f. Zip Code		1	0g. Citizen	of What Coun	try?	
Sa C		1025 Main St.				21740			TT	.S.A.		
ns 2	runerai	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or No-		Race - America	an Indian.	
The fire		1 ☐ Never Married 2 ☐ Marri	Armed Fo	rces?		If Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		Black, White, e	etc.	
0-18	2	3 ☑ Widowed 4 □ Divorced	If Yes Giv	/e A		1 ☐ Yes 2 🙀 No	Specify:		Spe	ecify: Whi	te	
a in the	ed		t's Education		16a, Dece	dent's Usual Occup	pation		16b Kind o	of Business/Ind	fustry	
c pag	Completed	(Specify only highe	st grade completed)		(Give	kind of work done DO NOT use retire	during most of wo	orking		or 20011100041110	ustry	
thar	E	Elementary/Secondary (0-12)	College (1	I-4or 5+)	Homer	nakor	-,		Domos	2+10		
Hyg int,		17. Father's Name (First, Middle,	Last)		Lionei	arcı	18. Mother's Na	ame (First, Middle, M	Domes			
Department of Hailth 2 should be maying 12 hours and begin min to maying Department of Hailth 2 should be maying the propertient: If item 27 is marked other than "natural", or items 23a or 28e-f ehow eny injury or other traumatic event, the Madical Examinal must be notified at once.	D D	Paul Avey						Moler		/		
d Me nark natic	0	19a. Informant's Name/Relations	hin /Tues Octob		105 11	a a Add (0)				C: -	0-71	
ls n	1			4				Rural Route Number				
m 27 m 27 her t		Cheryl L. Kokki	Lilos/Daugn				Island D	rive, Bis				813
of H If Ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	1 6	riace of Dispi cemetery, cre	osition (Name of matory or other pla	се)	Date	20c. Locati	ion - City or To	wn, State	
ant:		4 □ Donation 5 □ Other (S			t Have	en Cemete	ry 2/11	/2006	Hager	stown,	MD	
Departiment Import on Injury I		21. Signature of Funeral Service	Licepsee		2	2. Name and Addre	ess of Facility Re	estHaven I	Funera	al Chap	e1	
8952		Ky 7	15		> 1	601 Penns	ylvania	Ave., Hag	erst	own. MD	217	47
356		23a. Part I. Ent if the diserse, or shock, or heart failure. List	complications that c	aused the deat							Approximat Interval Bet	te
hysician //Medical standard physician and //Medical standard physician and standard physici	S S	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	or as a consequence or a consequ	uence of):	Varian	n Carca	noma			[\(\text{cu} \)	> 1
	ledi	IS SERVICE										
ate has been signed by the attending page 2 should be detached for use as	1ysician/n	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live b	come of pregna pirth 2 Feta pant at time of do pwn	Ideath 3	□Ectopic pregnanc	у		23d.	. Date of deliver Month	*	Year
igned t	D P	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	oacco use o	contribute to the	e cause of d	death?
in in its second	0							1 □ Ye	s 2 🗆 N	lo 3 🗆 Proba	ably 4	Unknown
should I	ered							24a. Was a		4h 18/	- Garden	
	Compi							autops perform	y	4b. Were autop prior to con death? 1 ☐ Yes	npletion of c	available ause of
certificate	Ď	25. Was case referred to medica examiner?						eath (Check only on	e)			
After this of funeral direction To	01:10	1 ☐ Yes 2 No 27. Mapner of _eath 1 ☐ Natural 5 ☐ Pendir	28a. Date		ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	y at rk?	Home 5 Reside)	
after death. Diractor: A in by the fu	eruncation:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho ng, etc. (Specif	ome, farm, st	M 1 □	Yes 2 □ No	28f. Location (St. City or Town		umber or Rural	Route Num	nber,
E SE O C	Medical	29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the Examiner: On the band man	best of my kno asis of examina ner stated.	wledge, deat	th occurred at the tire	me, date and plac opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and ate and pla	d manner as sta ice, and due to	ated. the cause(s	5)
withi Totl comp	2	29b. Signature and the of centres	terle	1.		29c. Licens	28)6°	7 2	9d. Date si	gred (Month, I	Day, Year)	
4		30. me ind address of person	rodeely	ay w	D. 1	209 Co	arteel K	Lighway F	awich	K Folce	el, Dr	1994
State		31. Date filed (Month, Day, Year)	2006	egistrar's Signa	ture	ills!		,			,	

Johnson, Juanita Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** Imogene James 27 2006 6:15p /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Nursing Home Hyattsville

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Prince George 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Director Yrs. 216-15-9275 59 13, 1946 Jamaica Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural; or Items 23a or 28a-f show the Medical Examiner must be notified at 1y Yes 2 □ No Director Maryland Prince George Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filad within 72 hours after death v Hygiene. 3201 Bunkerhill Road 20712 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 ™ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is markad oth any jury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Simeon Campbell Jestina Smithson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Palmer/Sister 3201 Bunkerhill Rd., Mt. Rainier, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 2/4/06 Brentwood, MD 22. Name and Address of Facility
First Lincoln Funeral Home
3401 Bladensburg Rd., Brentwood, MD 21. Signature of Funler of Service Licenses 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or its art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrythmia /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed baen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus autopsy performed? Yes 2 No Chronic Renal Failure certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To in by the luneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aman D19609 January 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli, M.D., 3503 Perry St., Ste B, Mt. Rainier, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 0 2 2006

DHMH 17 Rev 1/2001

Registrar

				partment of Health and Mental Hyg ertificate of Death	piene 006 04591
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Basil Lawrence Johnson	2. Date of Dea Month JUNIOT	4 31 2006 9:15 PM
	Examir	er	4a. Facility Name (If not institution, give street and number) Washington Co. Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington
e R	Funeral Director		5. Social Security Number 214-14-6128 6. Sex 2 F 84 Yrs.	Months Days Hours Min (Month, Day	9. Birthplace (State or Foreign Country) MD
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	the Mar 28a-f si	ector	MD Frederick 10e. Street and Number	Myersville	1 Yes 2 No
	th with	ai Dir	4349 Middlepoint Rd.	10f. Zip Code 21773	IOg. Citizen of What Country? USA
980	72 hours after death with the Maryland natural', or iteme 23a or 28a-f show lind Examities must be notilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1942 - 1 No 1	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ene. then "	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0·12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of working b. DO NOTuse retired) arpenter	16b. Kind of Business/Industry construction
/land	2 should be filed and Mental Hygi is marked other eumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Huron Johnson	18. Mother's Name (First, Middle, I Pearl Hays	Maiden Surname)
, Mar	무를 2 :		Pauline Johnson (Wife) 434	alling Address (Street and Number or Rural Route Number 9 $\mathtt{Middlepoint}$ \mathtt{Rd} \mathtt{Mye}	
altimore,	Pages 1 a nent of Hes ant: if itam ary or othe		20a. Method of Disposition 1X Burnati 2 Cremation 3 Removal from State 4 Denation 5 Other (Specific	rematory or other place)	20c. Location · City or Town, State Myersville, MD
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service I company	²² DonalddreB of FaThompson Fu 31 E. Main St., Middl	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician /Medical Examiner pup and pup parial-Itausit	Examiner	23a Pact Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respiratory arm	est, Approximate Interval Between Onset and Death
P.O. Box 68760,	I the death certifi by the attending ached for use as	Physician/Medicai		3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year bacco use contribute to the cause of death?
rds,	law requires that as been signed by 2 should ba det	ed by	CONGOSTIVE HEART	FAILURE 10/10	
Division of Vital Records,	The ta	Completed	CORUNADY ARTERY	DISPASE 24a. Was a autops perform	sy prior to completion of cause of
Z.	Physician: this certificatal director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1000 Hospital: 1 Impatient 2 ☐ ER/Outpat	26. Place of Death Check only on Interest 3 DOA Other: 4 Nursing Home 5 Reside	
sion of	ng frai	Certification: 7	27. Manner Death 1 In atural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c, Injury at 28d, Describe ho	ow injury occurred
DIV	tal or Att rs aftar d el Direct ed in by I	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attendi within 24 hours attar death. To the Funerel Director: A completely filled in by the fu	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de Check only one) Certifying Physician: To the best of my knowledge, de Check only one) Medical Examiner: On the best of my knowledge, de Check only one)	investigation, in my opinion, death occurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
)	5 with	Σ	29b. Signature and little of centuer	29c. License number 2	9d. Date signed (Month, Day, Year) 2 C(c
, O	+111th		30. Name and address of person who completed cause of death (Item 23a) (Type Completed Cause of Death (Item 23a)	1 Jetterson BUD I	in itusping in 21784
	Sta Registr	-	31 Sate filed (Month, Day, Year) 3 2006 FEB 0 3 2006	Sparle	

December March M				1 - State Registrar	State	of Maryla		artment of H rtificate of I			iene	16	04592
Victoria A. Rarpis February 8, 2006 10:15 A M 40 City Town or Location of Damb 40 City Town or Location of Damb 41 Ridge Avenue 10 County 10 City Town or Location of Damb 42 Ridge Avenue 10 County 10 City Town or Location of Damb 43 Ridge Avenue 10 County 10 County 10 City Town or Location of Damb 44 Ridge Avenue 10 County				1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	th	V	3. Time of Death
## Part of the control of the contro	Н			Victoria A.	Karpis								10:15 A M
## A Stridge Avenue ## A Stridge Avenue ## B Seed South Protection 176-20-3911	P			4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, or	Location of Death	h	4c. County	of Death	
The Document of Control Contro				43 Ridge Avenu	ıe			Edgewat	er		Anne	aru	ındel
The final final final content of the		Funeral		5. Social Security Number 6		7. Age (In y	rs. last birthday)			8. Date of Birth	Year)	9. Birthr	place (State or Foreign
The Sales 10c. Courty 10c. City, From or Location 10c. City,	L	Director			1 □ M 2 K □ F	77	Yrs.	morano Bayo	110010	May 21,	1928	Penn	sýlvania
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Yan Zdun Yan Sales Y	ဗ္ဗ	al'. o	þ		If Yes, G	ive		1∐ Yes 2M No	Specify:		Specify	" Wh:	nite
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Physician Medical Examinor Physician Medical Examinor Physician Medic				23a. Part1. Enter the disease, or co	omplications that	caused the d	eath. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory arr	est,		Approximate
Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying. Cause (Direct Industry) in the past 12 manning?		Physician		Immediate Cause (Final	ny 0110 02230 011	02011 1810.	Al-h		D	1			Onset and Death
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State Stat		Examiner		Sequentially list conditions	b								
Section Sect	_	D #	Iner	If any, leading to immediate cause. Enter Underlying	Dualto	(or as a none	sequanna of):						
Section Sect	V	ecute and trans	Cam	that initiated events	C. Due M	. /							
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State	_	ned t	Y P	Part II. Other significant condition	s contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	oacco use conti	ribute to th	he cause of death?
State	ğ	quire an sig uld b								1 □ Ye	s 2 No	3 🗆 Prot	pably 4 □Unknown
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30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Corose Cavanach MD 4201 Mitchelv. He RD Bowie, Mcl 20716 State 31. Date filed (Month, Pay Year) 06 32 Registrar's Signature	_	pital		29a Certifier 1X Certifying	Physician: To th	ne hest of my l	knowledge death	a accurred at the time	no data and place	and due to the o	21120/2) and ma		
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30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Corose Cavanach MD 4201 Mitchelv. He RD Bowie, Mcl 20716 State 31. Date filed (Month, Pay Year) 06 32 Registrar's Signature		within To th comp	X	29b. Signature and title of certifier	(, ,		1	29c. License	e number	2	9d. Date signed	d (Month,	Day, Year)
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				epartment of Health and Me Certificate of Death	ntal Hygier	Hun Hanya
	~		Decedent's Name (First, Middle, Last)	2.	. Date of Death	3. Time of Death
	Physici /Medio		Louise Kunc		22-01	-2006 1115 M
	Examir		4a. Facility Name (If not institution, give street and number)	4b Sity, Town, or Location of Death		4c. County of Death
		A 1	loastal Hospice at the Lak	e Salisbury		WICOMICO
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 M 2/1 F 91	Months Days Hours Min.	Date of Birth (Month, Day, Yes	
П	The state of the s		Usual Residence of Decedent		0-31-191	4 PENNSYLVANIA
	yland		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	e Ma	ctor	MD WICOMICO SALIS	BURY		1 ☐ Yes 2 ☐ No
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w	E .	316 WYMAN DRIVE	21801		USA
	ltem Inerr	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Specification of the Hispanic Origin). If Yes, specify Cuban, Mexican, Puerto Richard 	ty Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
936	urs at	þ	3 ¼ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: WHITE
21215-0036	filed within 72 hours atter death with the Maryland Hygiene. ther than "neturel", or Iteme 23a or 28a-f ehow thit, I'm Medical Exeminat must be netitied at	Completed	15. Decedent's Education 16a. C (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of working	16b.	Kind of Business/Industry
21	ithin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)		
	led w lygier her th		2	NURSE 10 Market Name (f		MEDICAL
Maryland	d ta b	Be	17. Father's Name (First, Middle, Last) ROGER GRAVER	18. Mother's Name (F		en Sumame)
Z	should ind Men i marke umatic	ြ		LAURA MA Mailing Address (Street and Number or Rural R		v or Town State Zin Code)
Ma	and 2 sealth ar	1		MURRAY HILL BLVD.NEV		
ē,	s 1 and 3 if Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	isposition (Name of Date crematory or other place)		Location - City or Town, State
Ë	Pages nent of int: if it		1 🗆 Burial 2 XI Cremation 3 🗆 Hemoval from State	ORY OF DELMARVA 02-02-	-2006 DEI	MAR, DELAWARE
Baltimore,	permit. Pages Department of Important: If It any Injury or c		21. Signature of Euneral Service Licensee	22. Name and Address of Facility BOUNI		
<u> </u>	89 = 5 8		Myllissa Key Herry	705 EAST MAIN STREET,	,SALISBUI	RY, MARYLAND 21804
			23a. Papt. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List got, one cause on each line.	t enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Cerebito Vascum	an Heident		Onset and Death)
	/Medical Examiner		Due to (or as a consequence of			
¥.	₩. — 3.	e.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	:		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events			
ó	be executed icien and burial-transit	Ex	resulting in death) Last Due to (or as a consequence of	:		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal	d.			
9	entific fing p	Mec	IF FEMALE:			
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
Q _	res that the signed by be detacted	by Ph	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Records,	w require: been sign should be	d be			1 🗆 Yes	20 No 3 Probably 4 Unknown
900	aw re	Completed			24a. Was an	24b. Were autopsy findings available
Ä		E			autopsy performed 1 Yes 2	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death C		
of \	Physical this call dire	ည	1 ☐ Yes No Hospital: Inpatient 2 ☐ ER/Outp		5 🗆 Residence	6 ☐Other (Specify)
n C	ding P. h. After i	lon:	27. Manner of Death 28a. Cate of Injury (Month, Day Year) Injury	ıry Work?	d. Describe how in	jury occurred
Division	I or Attendi after death. Director; A I in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	Location (Street	and Number or Rural Route Number,
Ω̈́	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	, street, factory, office	City or Town, St.	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director; After this certific; completely filled in by the funeral director.		29a. Centifier Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	To T	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
•	13		IN ELY, VIII	N26278	0	3-1-06
	20		30. Name and address of person who completed cause of death (Item 23a) (T	/pe, Print)	/	021862
dia.	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	00 Box 1733 Salis	54 101	DAISON
4	Registr		FEB 0 2 2006 Regue #	Angel s		

Decoders's Name (First, Middle, Last) STEPHANIE ANN LINDNER As Facility Name (If not institution, give street and number) As City, Town, or Location of Death As Cally Name (If not institution, give street and number) As City, Town, or Location of Death As County of Death As Cally Name (If not institution, give street and number) As City, Town, or Location of Death As County of Death As Cally Name (If not institution, give street and number) As City, Town, or Location of Death As County of Death As County of Death As County of Death As City, Town, or Location of Death As County of Death As County Number As County of Death As County of Death As County Number As Co	4000 04394	. Ensure All Copie Health and Mental H	k Indelible Ink 6 III Department of F Certificate of	Print in Blac C852 2/23/(Maryland/	se Type or P 7,28a-f. perME State of	Pleas cem# 23a,27	iner Unpend ite 1- For Registrar		phanie L 00794	
STEPHANIE ANN LINDNER January 31 2006 8:45		2. Date of I	- Commodito or		e, Last)	lame (First, Middle,				
Scheminer Cumber1and Memorial Hospital Cumber1and Allegany Allegany Cumber1and Allegany Social Security Number Social Security				NDNER	ANN LIN	PHANIE	STEP			
S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 dept 1 Year 11 Under 1 Year 11 Under 1 Year 12 Under 1 Year 13 Under 2 Hrs. 14 Under 2 Hrs. 15 Under 2 Hrs. 16 Under 2 Hrs.	7		4b. City, Town, o	mber)	n, give street and numb	e (If not institution,	4a. Facility Name			
Usual Residence of Decedent 100. Street and Number 100. City, Town or Location 100. City Town o	Allegany									m
10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lity 10c. City Town or Location 10d. Inside City Lity 10c. Street and Number 10d. Inside City Lity 10d. Inside City	9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) WEST VIRGINIA	Hours Min. (Month, I	Months Days			-				1/2
DAVID VINCENT LINDNER, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	10d Inside City Limits		or Location	10c. City. Toy					and	-
DAVID VINCENT LINDNER, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1 ☐ Yes ¾ □XNo			_	ERAL	MINE		ctor	e Maryl la-f eho	
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DAVID VINCENT LINDNER, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	Specific			2 XINo e	ned 1 ☐ Yes 2 If Yes, Give	_		by Fu	urs after	936
DAVID VINCENT LINDNER, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	16b. Kind of Business/Industry	pation	Decedent's Usual Occup	16a	t's Education	15. Decedent's	(So	ted	72 ho	2-0
DAVID VINCENT LINDNER, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	EDUCATION	d) " Host of Horaling	life. DO NOT use retire	-4or 5+)		econdary (0-12)	Elementary/Se	omple	d within giene. or then	2121
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Medical Amitriptyline intoxication Due to (or as a consequence of):		, ,		II	· _				ad in the control of	land
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Medical Amitriptyline intoxication Due to (or as a consequence of):	ber, City or Town, State, Zip Code)	and Number or Rural Route Num	Mailing Address (Street	198	hip (Type, Print)	s Name/Relationshi	19a. Informant's	-	shou and M mar	ary
RESTLAWN MEML.GARDENS 02/04/2006 LAVALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, onset and Death Physician (Medical Amitriptyline intoxication Due to (or as a consequence of):	,				MER, II/FAT				- 40 -	_
202 GREENE ST., CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Amitriptyline intoxication Due to (or as a consequence of):	N. C. M. P. C.	ce)	y, crematory or other pla	State cemete		2 Cremation	12XXBurial		ages 1 nt of H t: If ite	nore
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Medical (Medical Cause (Final disease or condition resulting in death) Amitriptyline intoxication Due to (or as a consequence of):	arrest, Approximate Interval Between			eused the death. Do ach line.	complications that ceu	er tha disease, or c heart failure. List o	23a. Part1. Ente shock, or he			
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			of):	or as a consequence	Due to (or				Examiner	
Sequentially list conditions, b. Due to (or as a consequence of):			A);	or as a consequence		t conditions, o immediate nderlying	Sequentially list of Tany, leading to cause. Enter Uni	ner	D ≃	
Cause (Disease or injury that initiated events c.			\\$\.	Ar ac a concequiance		or injury ents	that initiated ever	xam	o 7 7	
O o c c c c c c c c c c c c c c c c c c			n).	or as a consequence	000 10 (01				sicien buria	,09
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Due to (or as a consequence of): Constitution of the past 12 months? Due to (or as a consequence of):		v	3 Ectopic pregnance	come of pregnancy irth 2 Fetal death	23c. If yes, outco		23b. Was decede	an/M	th cert tendin r use	XOX
in the past 12 months? Column Colu	Month Day Year			ant at time of death	4 ☐ Pregnar	2 No	1 ☐ Yes 2	ystci	the dea	О.
v 8 8 8 1 €			the underlying cause giv	eath but not resulting i	ons contributing to dea	gnificant condition	Part II. Other sign	by Ph	ires that signed by	ds, P.
1 Yes 2 No 3 Probably 4 Unkn								ietec	w requirements	Cor
The state of the s	opsy prior to completion of cause of death?	aut per						ф	The la	Re
25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No						eferred to medical			cian: ertifica	ita
25. Was case referred to medical examiner? Solution Check only one		4 Nursing Home 5 He	Datient 3D DOX		1 ling		1 🔀 Yes 2 (2	Physic this c	5
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident 2 Ac	,					5 Pending	1 Natural	tion	ding ding After funer	on
1 Natural 5 Pending Pending Pending Natural 5 Pending Pe	(Street and Number or Rural Route Number	28f. Location		of Injury - At home, fa	not be 28e. Place of	6 ☐ Could no	3 Suicide	ifica	Atten r deat ector by the	Visi.
28d. Describe how injury occurred 28d. Describe how injury occurred	y, West Virginia, .	Kidgele			home	J6	4 Homicide		Ital or irs efte rai Dir	á
27. Manner of Death Natural Simple of the part of	e cause(s) and manner as stated. a, date and place, and due to the cause(s)	ne, date and place, and due to the pinion, death occurred at the time	, death occurred at the tire For investigation, in my o	isis of examination ar	exeminer: On the basi	1 ☐ Certifying 2 ☐ Medical E:	(Check only	dicai	• Hosp 24 hou • Fune etely fil	,
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	29d. Date signed (Month, Day, Year)	e number	29c. Licens			and title of certifier	29b. Signature ar	Æ	To the To the Complex	
Jash? Jelef up OCME February 1, 2006	February 1, 2006	CME		el mo	Jele	ashSZ	10			
30. Name and address of person o completed cause of math (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	imore Maryland 21201	on Street Ralt.		4 - 0	45			12		
The state of the s		Dant.		* 2 /						
State Registrar FFB 1 6 2006 DHMH 17 Rev 1/2001		-1.:	Jan.	Marie 15	6 2006	FEB 1 6	1			D

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			1 - For State Registrar	otato or mar		rtificate of			Reg. No. UU b	04595
	_s Physici	an	1. Decedent's Name (First, Middle, La.	avegory 1	nathis			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin		4a Eacility Name (If not institution also			4b. City, Town, o	or Location of Death	City	4c. County of Dear	th
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday) If Under 1 Year	II Under 24 Hrs.	8. Date of Birti (Month, Day	h 9. Bir	thplace (State or Foreign
	Funeral Director		578-60-3354 Usual Residence of Decedent	Ж ^{М 2□ F}	58 Yrs.	Months Days	Hours Min.		16,1947	Wash.,DC
	yland how		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
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	with the or 2	Dire	10e. Street and Number	CE #102		10f. Zip Code 2002(2		10g. Citizen of What Co	
	death	nera	2700 Q Street,	SE #103 12. Was Decedent Ev Armed Forces?	er in U.S. 13		Hispanic Origin? (Spo ean, Mexican, Puerto		United St 14. Race - Ame Black, Whit	erican Indian,
336	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menthal Hygiene. If the 27 Is marked other than "natural," or Itame 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No		, , , , , ,	Specify:	ack
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	be filed tal Hygi d other event, ti	BeC	17. Father's Name (First, Middle, Last		u	CK DIIV		e (First, Middle,	Maiden Sumame)	
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Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Locola F. Math		er 320	5 Radfoi	rand Number of Hur. od Lane ogton, M:		er, City or Town, State,	zip Code)
ore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Surial 2 Cremation 3		20b. Place of Disp	position (Name of ematory or other pla	and the same of th	Date	20c. Location - City or	Town, State
Baltimore,	mit. Pages partment of cortant: If it injury or o		4 ☐Donation 5 ☐ Other (Special	ý)	Resurr	ection (Cem. 2/6	/06	Clinton,	
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice	od 11)					Edwards Suitland,	
			23a. Parri. Enter the disease, or com shock, or heart failure. List only	plications that caused the						Approximate
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):			NABADAET BA MED	CH	
	be executed iicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):		m	APPROVED B		
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.O. Box	a death he etter ed for u	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of de Month	Day Year
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Records,		eted	_ metastatic	prostace	- Canc			24a. Was		robably 4 Unknown utopsy findings available
l Rec	The la ate has page 2	Sompl						autor perfo	osy prior to death?	completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	40.500		26. Place of Deat			
of	this a	n; To	1 12 Yes 2 □ No 27. Manner of Death	28a. Date of Injury	28b. Time	ol 28c. Inju	4 Nursing no		dence 6 Other (Spe how injury occurred	ecity)
sior	eath. for: After the funer	catio	1 □ Natural 5 □ Pending 2 ☑ Accident investigation 3 □ Suicide 6 □ Could not be	01/30/0	06 16:0	O M 10	Yes 2 No	fall	from Stane	
Division of	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I cumpletely filled in by the funeral	Certification:	4 Homicide determined		y - At home, larm, s (Specify) H	Spike		28f. Location (. City or Tou	Street and Number or Fi wn, State)	amal Moure Number,
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	To the Mithin 2 To the	Med	29b. Signature and title of certifier	and mainer state			ise number		29d. Date signed (Mon	
							536		01/31/	
L	(4)		30. Name and a dress of person who	JOHNIN	ath (Item 23a) (Typ	outh Giv	neen St.	Balti	more, mo	. 21215
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	E)	/		-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** PUSHPA MADAN JANUARY 31 3:47 P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOŞPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 219-65-8924 70 Director March 6, 1935 India Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Maryland Frederick Walkersville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 153 Polaris Drive 21793 India Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home Department of Heelth and Mental Hygie Important: if item 27 is marked other t any injury or other traumatic event, IL QRCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ram Pyari Madan Tulsi Das Dhingra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Chawla - daughter 153 Polaris Drive, Walkersville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Frederick Crematory 2/3/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Sharon 1621 Opossumtown Pike, Frederick, Maryland anulle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ MYOCARDIAL INFAR CTION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RSSPIRA TORY 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours e To the Funeral C Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-57796 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Street, Frederick, Maryland Lalit Verma 31. Date filed (Month, Day, Year) State FEB 0 3 2006 Registrar

		1 - For State Registrar	State of Ma	aryland		artment of F				Reg. Np.	006	045	97
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/Medi Examir		4a. Facility Name (If not institution, ga	ve street and number)			4b. City, Town, o	r Location				County of Death		
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Funeral Director		350-20-9204	1□M 2∏F	88	Yrs.	Months Days	Hours	Min.	8. Date of Bir May 27	, 191	7 Ch	icago,	IL
rland ow		Usual Residence of Decedent 10a, State 10b, County	17.1	10c. City	, Town or Lo	cation						10d. Inside 0	Dity Limits
e Man 3a-f sh lifted	ctor	MD Montgor	nery	Beth	nesda							½ Yes	s 2 No
with this a or 26	Dire	10e. Street and Number 4974 Sentinal Di	· #203			10f. Zip Code 20816					izen of What Co ted Sta	-	
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aryid should I and Meni s marke umatic	P	Harry Johnson 19a. Informant's Name/Relationship	(Tyne Print)		19b Mailir	ng Address (Street			guire	er City o	r Town State 7	in Code)	
and 2 s and 2 s ealth an n 27 is er trau		Dr. Francis Muri		d		Sentinal							
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Oi Vital F Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? ↓☐ Yes 2☐ No	Hospital:	ant 2 🗆 I	ER/Outpatier	it 3□ DOA Oth			(Check only o		6 □Other (Spec	uhr)	
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•		30. Name and address of person wh				Print) chusetts	A370	M t	J C	o 30	O Wash		0016
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			1 - For State Registrar	State of Ma			ent of F ate of		nd Me		giene Reg. No	000	0	4598
,	Physici	an	Decedent's Name (First, Middle, La	•					2	. Date of Dea	ath Da	y Ye		3. Time of Death
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	th the	Director	10e. Street and Number			10f.	Zip Code				10g. Cit	izen of What	Country	?
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336	be filed within 72 hours after death with the Marylan Ital Hygiene. d other then "natural", or Iteme 23a or 28a-f show event, the Medical Exameraer must be tradified at	by Funerai	11. Marital Status Compared 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☑ XI If Yes, Give Year or Dates:		If Yes, s	cedent of H specify Cuba s 2 No	ispanic Origin an, Mexican, P Specify:	i? (Speci Puerto Ric	ly Yes or No- can, etc.)		14. Race - A Black, W Specify:		
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and	should be find Mental be marked of	o Be	Clifford Mo							First, Middle, i Hal		Sumame)		
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altimore,	Pages 1 nent of He int: If iter		20a. Method of Disposition 1	Removal from State		crematory of	or other plac	(a)	Dat			cation - City		
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n n	permit. Departi Import eny inj		EONEK.	nowa	ller	246	N. W	lash.	St.	, Roc	kvi		MD	E, P.A. 20850
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	licate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
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0	ng Ph Iter th neral	T ::	27. Manner of Death 1 □ Statural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Tim	e of	28c. Injun Work			d. Describe h			pochy	
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	he Hosp n 24 hou ne Fune bletely fil	edicai	29a. Certifier 1 Crecifying Ph (Check only one) 2 Medical Exam	ysician: To the best o iner: On the basis of and manner stat	examination and/o	eath occurr r investigati	ed at the tim on, in my op	ne, date and po pinion, death o	ace, and	due to the d at the time, d	ause(s) date and	and manner place, and o	as state	ed. e cause(s)
	To th To th comp	M	29b. Signature and title of pertifier	0 •			29c. License	number		2		e signed (Mo		v. Year)
-	25		1 69	14	\		D4	5880				1/31/	06	
			30. Name and address of person who				_		_			0.0.0		
150	Sta	te	Leon C. Hwang 31. Date filed (Month, Day, Year)	, M.D. 1	r'e Signature	40		e, Ro	CKV	ııle,	MD	2085	U	
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State of Maryland / Department of Health and Mental Hygiene 04599 AMEND #10b/cperFH2/8/06, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 30, 2006 **Physician** 0500 Shinzo Nakai /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SPRING SANDY BROOKE GROVE ASS IS TED LIVING MONTGOMERY If Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 82 Yrs. Director June 25, 1923 237-74-0728 Japan Usual Residence of Decedent show 10a. State 10b. County Montgomery 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at once. Sandy Spring 11☑ Yes 2 □ No Director Maryland - Montgonery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1639 Hickory Knoll Road 20860 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ Specify. 3 St Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Physics Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shikazo Yokoi Tora Yokoi ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3217 Wisconsin Ave. #5A, NW; Washington, DC 20016 Hiroshi Nakai / Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 2/2/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SQUAMOUS CELL CARCINOMA OF THE HEAD disease or condition resulting in death) Examiner Due to (or as a consequence of): AND NECK Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician s s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use as attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown ENCEPHA LOPATHY WERNICKE'S δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 26. Place of Death (Check only one)

Other: 4□ Nursing Home 5□ Residence 6 Cother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ဠ funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? within 24 hours efter death.

To the Funerel Director: After of completely filled in by the funer Certification: 1. Watural To the Hospital or Attending 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Funel completely fi (Check only one) 29b. Signaline and title of certifier 29d. Date signed (Month, Day, Year) 042046 ATTENDING PHYSIUM 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHACE BLOOKE HUFFMAN, M.D. (8100 SLADE SCHOOL ROAD SANDY SPLING MARYLAND 31. Date filed (Month, Day, Year) State FEB 02

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Physician 31, 2006 7:40 P. January Suzanne Pennoyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 3421 Larkington Drive Edgewater If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖵 F Wash. Director 218-46-3190 Mar. 22, 1944 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "naturel", or Iteme 23a or 28e-f ahow the Medical Exeminer must be notified at 1 Yes 2 No Director Md. Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 USA 3421 Larkington Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "naturel", or Iter 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XNo White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance agent Insurance 18. Mother's Name (First, Middle, Maiden Sumame) other traumatic avant. 17. Father's Name (First, Middle, Last) Be Thomas Carpenter Mary Oderman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 to Paul Pennoyer - Husband 3421 Larkington Dr., Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If Ite 02-04-06 1 Burial 2 □ Cremation 3 □ Removal from State injury or permit. Page Department of Importent: If any injury or Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 N.W.Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain Canter Physician eight disease or condition resulting in death) /Medical months Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initial order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (unas a consecuence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🗹 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 2 🗆 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificete 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No I Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Cartifier (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Road #300 B Keyn 31. Date filed (Month, Day, Year) State 2006 Registrar

AEM 06-00686 John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene	n	1
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	d within 72 hours after death with the Maryland jiene. r then "natural", or itema 23a or 28e-f ehow the Medical Examinar must be notified at	Funeral Director	11. Marital Status		12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of if Yes, specify Cu	Hispanic Or	igin? (Spec	ify Yes or No)-	14. Race - Amer	ncan Indian,
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ary	2 should and Men is marke	-	19a. Informant's Na	ame/Relationship (7	ype, Print)		19b. Maili	ng Address (Stre	et and Numb	er or Rural	Route Numb	er, City o	r Town, State, Z	ip Code)
Ž	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Diana Rol	berts/Ex-	Wife		8902	Berwick	Pl.	Ijams	ville,	MD	21754	
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Baltimore,	permit. Pages to Department of Himportant: If ite any injury or ot once.		21. Signature of Fu	ineral Service Licen	der M	01442		2. Name and Add .12 Old (ily FH, Inc MD 21043
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) Ji	ma ?	Jeef	MD			OCME			Janı	uary 29,	, 2006
Œ	100		30. Name and addi	ress of perso who	completed cause	of death (Iten	n 23a) (Type,	Print)			,			

(5)00 Registrar

Tasha Zaveensern 31. Date filed (Month, Day, Year) 32. R JAN 3 1 2006

M.D

111 Penn Street Baltimore, Maryland 21201

	For	State of Maryland / Department of Health and M	ental Hygiene
1-	For State Registrar	Certificate of Death	Reg. No.
1. [Decedent's Name (First, Middle, Last)		2. Date of Death

006 04602

3. Time of Death

	Physici /Medic		Naimeh	Rizkallah		Jan. 30	, 2006 Year	2256 M
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Holy Cross Hosp	ital	Silver Sprin	g	Montgome	ery
	Funeral Director		5. Social Security Number 6. Se 120-74-9237	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 4 / 21 / 1	9. Birthp	place (State or Foreign ptry) istine
			Usual Residence of Decedent			4/21/13	734 Pal.	istine
	yland how		10a. State 10b. County	10c. City, Town o			1	0d. Inside City Limits
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	item	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	72 hours after deeth with the Maryland naturel', or iteme 23a or 28a-f ehow dical Examiner roust be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Wh	ite
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lanc	uld be fi dental P rked of tic ever	To Be	17. Father's Name (First, Middle, Last) Abrahim Rizkal	lah	Jaleha	Farr	den Sumame)	
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	Heelt Heelt em 2		20a. Method of Disposition	20h Place of Di	enocition (Name of		. Location - City or To	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not	enter the mode of dying, such as cardiac of		_ DPIING	Approximate Interval Between
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¥ 68	ertifica ling pl	Med	IF FEMALE:					
Box	ath ca attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delive Month	ry Day Year
o.	the de		1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			,
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	ding Ph h. After th funeral	lon	27. Manner of Death 1 1	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how in	njury occurred	
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Θį	P P P P	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	allost, rasisty, since	City or Town, Si	ate)	THOUSE HUMBER
	To the Hospital or At within 24 hours efter of the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To t com	ž	29b. Signature and title of certifier		29c. License number D20400		Date signed (Month, I	
	3		- Wurks M	nen J	D20400		Feb.1,20	
			30. Name and address of person who came Mark Rossen M.	ompleted cause of death (Item 23a) (Tyr D 3941 Ferrara		2090s		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 20	32 Registrar's Signature		2000		
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p. it	Physici	an	1. Decedent's Name (First, Middle, La		±			2. Date of Deat Month		3. Time of Death
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10 c	Funeral Director				(In yrs. last birthday, O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Nov. 10	Year) 9. Birth Co. Pe.	place (State or Foreign intry) nna .
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	h with the 23a or 28	Funeral Director	10e. Street and Number 8812 Transue	Drive		10f. Zip Code 208	17	1	0g. Citizen of What Co USA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantal Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show may injury or other traumatic event, it is Madical Examinar must be neitlied at once.	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1X Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of it If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puen Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: W	
Baltimore, Maryland 21215-0036	d within 72 ho jene. r than "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup a kind of work done DO NOT use retire ministra	during most of word)	rking	Pennsylv Dept.of	^{ndustry} ania Education
/land	unid be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Las Aaron Stein)			18. Mother's Nar Fanny	ne (First, Middle, M Jacob		
Mar	olth and 1		19a. Informant's Name/Relationship Marlene A. Sch	Type, Print) nooler/Nie	ece 920	ng Address (Street 1 Quint	and Number or Ru ana Dri	ve Bethe	City or Town, State, Z	208 ¹ 17
more	nent of He ant: if from		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cre Kesher	osition (Name of matory or other pla Israel	em. 1/2	Date 9/06 I	20c. Location - City or 1 Harrisbur	
Balt	permit. Departr Imports any inji		21. Signatury 11 Furneral Service Lice	willy	p ²	HILIP D	RINALD	I FUNERA	AL SERVIC	E,P.A. g,Md20910
8760,	Physician by swearled by single and physician and physician and the physician in the private in the private in the private in the physician physic	Ical Examiner	23a. Par1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Failu. Due to (or as a b. Due to (or as a c. Separate	re to the consequence of): Onia		ng, such as cardiad	c or respiratory arre	est,	Approximate Interval Between Onset and Death
P.O. Box 68	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc	/		23d. Date of deliving Month	very Day Year
	uires thet the de signed by the a lid be detached f	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giv	ren in Part I.		eacco use contribute to	
Il Records,	ysician: The law requires that the is certificate has been signed by the director, page 2 should be detach	Completed						24a. Was an autops perform	y prior to c ned? death?	opsy findings available ompletion of cause of
VIta	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					ath Check only on	9)	
0	Physi this c	2	1 Yes 2 No	Hospital:			4 A Nursing F		nce 6 Other (Spec	(fy)
Division	ding l	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 5 Pending investigation 6 Could not be	e		M 1	yat k? Yes 2 □ No	28d. Describe ho		
Div	P ff o		4 Homicide determined	building, etc.				City or Town		
	To the Hospitel within 24 hours a To the Funerei completely filled	edical	29a. Certifier 1 Certifying P	nysician: To the best of miner. On the basis or e and manner state	xamination and/or in	n occurred at the til ivestigation, in my o	ne, date and place pinion, death occu	red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier 30. Name and address of erson who	complet Trause of dea			e number 051280	29	9d. Date signed (Month Jan. 31, 2	
	Sta Registr		Anushiravan 31. Date filed (Month, Day, Year)	Dadgar D.	O. 9715		Center	Dr.Roc	kville,Mo	120850

		_	1 - State Registrar		artment of Health and rtificate of Death	Mental Hygiei	No. UUD U	4604
	Physici	an	1. Decedent's Name (First, Middle, Last) Raymond James S	· A e u c e			Day Year	Time of Death 7:50 PM
	/Medic		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Dea		4c. County of Death	7.501
	Examin	er	Union It os Pital of Ce		Elkton		Cecil	
	Funeral Director		5. Social Security Number 6. Sex 1004 22 0346 100 100 100 100 100 100 100 100 100 10	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min			(State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation		10d. I	nside City Limits
	Mary Ba-f sh	tor	MD CECIL	EARLEVI	LLE			I ☐ Yes XX No
	th with the 23a or 28 and be not	ai Dire	10e. Street and Number P.O. BOX 35		10f. Zip Code 21919	10g.	Citizen of What Country? U.S.A.	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examena must be notified at	by Funeral Director	1 Never Married 2 Married 1 MYe	ecedent Ever in U.S. Forces? Forces? Siz 2 \sum No Give 1951 - or Dates: 1952	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American II Black, White, etc.	·
1215-0036	vithin 72 ho ne. han "natur "Wedical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	. Kind of Business/Industr	•
Maryland 21	ould be filed with Mental Hygiene arkad other tha atic evant, the	To Be Col	10 17. Father's Name (First, Middle, Last) BOWEN SPENCE	BUSI		me (First, Middle, Maid	•	
	ss 1 and 2 should of Health and Men itam 27 is marka r other traumatic		19a. informant's Name/Relationship (Type, Print) EARLINE SPENCE		ng Address (Street and Number or F BOX 35, EARLEVI		•	de)
Baltimore,	Pages 1: nent of He int: if itan iry or oth		20a. Method of Disposition 1 XX urial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)		position (Name of matory or other place) FT CEMETERY FET	3 10	NWOOD, PA 19	
Balti	permit. Pages Depirtment of I Important: If its any injury or of		21. Signature of Funeral Service Lipensee CHARLES F. MEALEY.	JR.M00784	PATE AND Address of Facility HO	MES, PO BO	X 2866, WILM	ington
	Physician /Medical		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	at caused the death. Do not en	,	ac or respiratory arrest,	Inte	proximate erval Between set and Death
8760,	certificate be executed ding physician and ise as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to minimiduals cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of).	Ineumonia Bleeding		7	d 175
P.O. Box 68	ath certific attending p	Completed by Physician/Medic	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	, Year
	w requires that the de been signed by the should be detached	d by Pł	Part II. Other significant conditions contributing			23e. Did tobac 1 ☐ Yes	co use contribute to the ca	
Il Records,	The lay ate has page 2	Complete	Acute oliquic Diabetes Type	T		24a. Was an autopsy performed	death?	tion of cause of
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	1	Othor	eath (Check only one)	- 50	
Division of Vital	ding After fune	tion: To	27. Manner of Death 28a. D	Minpatient 2 ☐ ER/Outpatie ate of Injury Month, Day Year) 28b. Time of Injury	HIL 3 DOA 4 INDISING	Home 5 ☐ Residence 28d. Describe how	e 6 Other (Specify) injury occurred	
Divisi	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm, s uilding, etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rural Ro itate)	oute Number,
	To the Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical ((Check only 2 Medical Exeminer: On the	the best of my knowledge, dea se basis of examination and/or in nanner stated.	th occurred at the time, date and place overstigation, in my opinion, death occurred.	ce, and due to the caus curred at the time, date	e(s) and manner as state and place, and due to the	1. cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	- 11.0	29c. License number		Date signed (Month, Day	
			· age at an	WO	D0055/9	10 Fe	brung 5,	6006
8	+IVA		30. Name and address of person who completed	cause of death (Item 23a) (Type	Husnifel 106 B	13 . +2 wo	Kton. MD	21921
	Sta Regist		31. Date filed (Month Day, Year) 1 TEB 0 8 2006	Registrar's Signature	truspetal, 106 B			

Fabienne Stassen 06-01026 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a,27,28a-f, penff, C653,3/6/06 II State of Maryland / Department of Health and Mental Hygiene | | | | | | | | | |

04605 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Hubertine Stassen Josephine February 9 2006 5:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner 223 North Boulevard Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7/5/1972 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1 ☐ M 2 🖰 F Months Days Yrs. 167-62-2255 33 New Jersey Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County show rthan "natural", or Itema 23a or 28e-f shov tre Medical Examinar must be notified at 1 XYes 2 No Directo Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 223 North Blvd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd Mental I Catharina Josephina Eussen Frans L. Stassen Pages 1 and 2 should 19b. Mailing Address (Street an Aptriber or Rural R Cambraidge Town, State, Zip Code) 02141-19a. Informant's Name/Relationship (Type, Print) 6 Canal Park, Suite 410, Salisbury, MD 21804 2212 t of Health a Frans L. Stassen/father or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【SCremation 3 ☐ Removal from State artment ortant: If injury or 2/12/06 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Depart Import any in Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 501 Snow Hill Rd, Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hydrocodone and Oxycodone intoxication and alcohol use /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off-Examine To the Hospitel or Attending Physician: The law requires thet the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown should I 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete has t irector, page 2 s 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence MOther (Specify) Scene မှ 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No death. Fnd 5:10 PM Find 2/9/2006 I Director: / unk 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 223 North Blvd. 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by ti 4 | Homicide Salisbury, MD House 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2/DMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NB10, MD ANA 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEBI3 Registrar

			For State Registrar	State	of Marylan		artment of H tificate of I		Mental Hygi	ene 0 0 6	04606
70	Physici	an	1. Decedent's Name (First, Middle	e, Last)				·	2. Date of Death Month	Day Year	
Ça.	/Medic	al	4a. Facility Name (If not institution		n H. Tyl	.er	4h City Town o	Location of Death	January	28, 2006 4c. County of De	10:56 A.M
	Examir	er	Washington A			1	Takoma			Montgome	
	Funeral Director		5. Social Security Number 579–50–8350	6. Sex 1. 3 M 2 ☐ F	7. Age (In yrs. 6	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 29	9. B	inthplace (State or Foreign Sountry) shington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -fehc	tor	Md. Prince	e Georges			Bowie				1∑Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	Country?
	s 23a	ral	13103 Bowie S					715		USA	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ta Madical Exerciter mail the notified at	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrial 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 ⊈No Sive	ĺ	Vas Decedent of H f Yes, specify Cuba l □ Yes 2 1 No	ispanic Origin? (Sin, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ал Black, Wh Specify: В	ite, etc.
5-0036	72 hou	ted	15. Deceden (Specify only higher	it's Education	0	16a. Deced	ient's Usual Occup	ation	kuna	16b. Kind of Busines	s/Industry
2121	within lene. then "	omple	Elementary/Secondary (0-12) 9th	<u> </u>	(1-4or 5+)	Mana	DO NOT use retired	n)	all g	Park	ing Garage
	be filled all Hygi d other	Be	17. Father's Name (First, Middle,				-5		ne (First, Middle, M	faiden Sumame)	
Maryland	d Ment d Ment narke natic	P	John Ty			400 14-77-			abeth Smi		7.0.41
	and 2 sl alth an 127 is r er traur		19a. Informant's Name/Relations Jeannette Tyle		se)3 Bowie			City or Town, State,	715
timore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow amy njury or other traumatic event, the Medical Evantiest must be notified at an ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State	emetery, cren	sition (Name of natory or other place nal Cemet	ery Feb	Date 2	Laurel,	
Balt	Deports Imports any nj		21. Signature of Funeral Service	Licensee	Staxts				eall Fune . Bowie,		
Ī	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	caused the deat each line.		1	g, such as cardiad ebra	^	etion	Approximate Interval Between Opset and Death
	/Medical Examiner		resulting in death)		o (or as a conseq				77, 3		& wente
êş.	p E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dye	o (or as a conseq	uence of):					1
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မှ	Sertific ding pl		IF FEMALE:	23c If was o	utcome of pregna	1004					
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ō	Physe Price or this eral di	n: To	1 X Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time of	3000	+ □ IAntzillà ⊔	ome 5 Reside	nce 6 Other (Sp w injury occurred	pecify)
ion	ath. or: Afte	atlo	1 □Natural 5 □ Pendir 2 ☑ Accident investi	gation Jan.	8, 2006	un Khou	Vh M 1□	k? Yes 2 No	Pall		
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	the Hospital or in 24 hours afte the Funeral Dire	Medical	29a. Certifier 1 Certifyir (Cireck only one)	Examiner: On the	he best of my kno basis of examina inner stated.	wledge, death	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complete	2	10	omsko.	May, m	d		51916		Jah, 31	
1	(4)		39. Name and address of person Pathicia Townsko	who completed ca	use of death (Item 9 Rock)	11/e	Print) IKE, G-/L	10, Rock	ville, MI	20852	
A. C.	Sta Registi		31. Date filed (Month, Day, Year)	006	Registrar's Signa	ature de	E)				

State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death			Reg. No.	0	030	0 1
			1. Decedent's Name (First, Middle,	ast)						2. Date of De		Voor	3. Time o	Death
	Physici /Medio		EDWARD LEG	ON TEL	LIS	SR.				Janua	ry 30, 2	006	12:1	0PM
1	Examir		4a. Facility Name (If not institution, g					4b. City, To	wn, or Loc	cation of Deat	h 4c. County	of Deeth		
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	Funeral			. Sex 7. Ag	e (In yrs. last bir	thday) If Und	er 1 Year	If Under	24 Hrs	0 D.4 (D:			lace (State of	
	Director		419-30-4159	123 M 2□F	79	Yrs. Month	Days	Hours	Min.	March	5, 1926		nnesse	
	ס		Usual Residence of Decedent											
	how how	١. ا	10a. State 10b. County		10c. City, Tow	n or Location						1	0d. Inside C	_
	a-fs	혅	Maryland Princ	e George's		Cl	into	n					1 X Yes	2 □ No
	# 28 E	Director	10e. Street and Number			10f. Z	ip Code				10g. Citizen of V	Vhat Coun	itry?	
	1 wil		9211 Stuart La	ne				20735	5			USA		
	be filed within 72 hours after death with the Maryland tel Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Dec	edent of		igin? (Spe	cify Yes or No		e - Americ		
)	or ite		1 X Never Married 2 ☐ Married	Armed Forces?	No	1 ☐ Yes	1			Tioan, etc.)		: Afr	_	
215-0020	al', e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I La res	ZUZINO	Specify:			Specify		ericar	2
<u>ဂ</u>	72 h	Completed	15. Decedent's (Specify only highest of	Education	16a	Decedent's Us	ual Occu	pation	at of working	na	16b. Kind of Bu			
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7	filed with Hygiene. sther than ent, the M	ő	12				Bar	ber			Self E	mplo	yed	
Maryland	e e for the transfer of the tr	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle	, Maiden Surnan	ne)		
<u> </u>	should be and Mentel marked o	흔	Henry Tell	is				Cor	reene	Unk	nown			
<u>a</u>	2 sho end is me		19a. Informant's Name/Relationship	(Type, Print)	196	. Mailing Addre	ss (Stree	t and Numbe	er or Rure	l Route Numb	er, City or Town,	State, Zip	Code)	
	s 1 and 2 should if Health end Mer item 27 is marke other traumatic		Joyce Milam	Granddaught	er 12	2606 Wat	er F	'owl W	ay (Jpper M	Marlboro	, MD	2077	4
Š	of He		20a. Method of Disposition	□D	20b. Place o cemete	f Disposition (A ry, crematory o	ame of other pla	ice)		Date	20c. Location -	City or To	wn, State	
Ĕ	Peges nent of I int: If ite iry or o	1.9	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Fort	Lincoln	Cem	etery	2	/4/06	Brentw	7000d,	MD	
altimore,	permit. Peges Department of Important: If it any injury or once.		21. Signature of Funeral Service Lic	ensee					ty Jor	dan Fu	neral Se	rvic	e. Inc	
מ	e d E e d	ls 10	Hun dela.	1. 1.	/						shington		2001	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do							,	Approxima	ite
	Physician		shock, or heart failure. List or	ly one cause on each li	ne.							İ	Interval Be Onset and	Death
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	Examiner		disease or condition resulting in death)	a. Alznei	mer's D		٤١.				,,	1		
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Vital Records,			25. Was case referred to medical					OC Disease	a of Dooth					
5	Attending Physician: or death. ector: After this certific by the funeral director,	o Be	examiner?	Hospital:	ent 2 ER/O	utpatient 3□	01			(Check only	idence 6 □Oth	or (Cassit	5.1	
ō		. To	27. Manner of Death	28a. Date of Inju	iry 28b.	Time of	28c. Inju				how injury occur		y)	
<u> </u>	ding th. Afte	ţ	1 🖾 Natural 5 🗆 Pending 2 🗆 Accident investiga	(Month, Da	y Year)	Injury M		ork?]Yes 2∐	No					
S	dea ctor	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inj	ury - At home, fa	arm, street, fact	ory, office		2		(Street and Numl	per or Rura	al Route Nu	mber,
Division of	* # - ⊂	Certification:	4 ☐ Homicide determin	building, ef	c. (Specify)					City or To	wn, State)			
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in		29a. Certifier 1X Certifying	Physician: To the best	of my knowledge	e, death occurre	d at the t	ime, date an	nd place, a	and due to the	cause(s) and ma	anner as s	tated.	
	• Ho 1 24 t	edical	(Check only 2 ☐ Medical Ex	caminer: On the basis of and manner sta	f examination ar	nd/or investigati	on, in my	opinion, dea	ath occurre	ed at the time	, date and place,	and due to	the cause	(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		2	9c. Licen	se number		1	29d. Date signe	d (Month,	Day, Year)	
	7 0		1 100-	- Johns	lh		יצת	5206			Januar	y 31.	, 2006	5
	10)		30. Name and address of person w	no completed cause of c	death (Item 23a)	(Type, Print)						1		
	(4)		William T. Tanı				Road	i_ #1∩	1 Fo	rt Was	hinaton.	. MD	2074	4
	Sta	ate	31. Date filed (Month, Day, Year)	. Registr	ar's Signature		·····	, ,,,,	•					
	Regist		FFR 0-2 20	201	K	hack ,								

DHMH 16 Rev 6/95

Robert M. Thomas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00904 Unpend item#23a,27,28a-f. perMe (2853,3/8/06 TT Department of Health and Mental Hygiene UU 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Michael Thomas February 05, 2006 5:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Y 6. Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** , 1980 Illinois Months Days Hours Min Yrs. 220-15-4854 Director 25 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examiner must be nutitled at 1 ☐ Yes 2 X No Director Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 Camp Hedges Place 20616 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 2001 -02 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **US Marines** Lance Corporal permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othners only Injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carol Helen Walline Robert Hilton Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Camp Hedges Place, Bryans Road, MD 20616 Dawn C. Thomas - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem 2-10-2005 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 3035 Old Washington Road S. Jukaun POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Contact gunshot wound of chest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physicien: The law requires that the death certificate be executed by the attending physicien and tached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ s been significant 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 XYes 2 □ No 2 ER/Outpatient 3 DOA Director: After this in by the funeral of 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 No Subject shot himself 2/5/06 3:15 2 Accident A 6 Could not be 3 X Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7281 Carroll Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter Dire 4 Homicide residence Bryans Road, MD within 24 hours e To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 05, 2006 40 30. Name and address of person who completed cause of the ath (Item 23a) (Type, Print) THEUDORE 111 Penn Street, Baltimore, Maryland 21201 mp 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 1 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** January 31, 2006 Trimble 5:30 A. M Koenig /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 112 Apple Creek Road Frederick 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 M 2 F Florida 215-74-7734 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1 Yes 2 No Frederick Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked othar than "natural", or items 23a or 21702 U.S.A. 112 Apple Creek Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 7 is marked othar than "natural", o traumatic evant, tre Modest Examples 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lois Madsen George Donald Koenig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 112 Apple Creek Road, Frederick, Maryland 21702 itam 27 i Terry Trimble - husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Oppartment of H Important: If its any injury or of once. 1 Burial 2 Decremation 3 Removal from State 2-1-2006 Frederick Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signaty of Funeral Service Licensee Sharow allue 1621 Opossumtown Pike, Frederick, Maryland anille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (Androvalcular tmmediate Cause (Figure disease or condition resulting in death) heroscleronc Syenn Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by silve 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 24 hours a Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1.06 20125000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 2,702 180 Thu, MO Da L. KRANTZ Johnson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 03 Registrar

State of Maryland / Department of Health and Mental Hygiene] [] [1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Tenet Toee 30°, 2006° January 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1098 West Side Drive Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2K F 212-63-7223 73 Yrs Director Feb. 16, 1932 Liberia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Count 28a-f ehow injury or other traumatic event, the Medical Examiner man be untilized at 1 ☐ Yes 2X No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with ŏ 1098 West Side Drive 20878 or Itams 23a Liberia death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 233 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced **Black** 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If them 27 is marked other the any injury or other traumatic event. Homemaker Own Home None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Available Not Available Toee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Barjolo (Daughter) 1098 West Side Drive Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. Ŀl, Silver Spring, Md. Gate of Heaven Cem. 2006 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seizure Disorder /Medical Examiner Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine certificate be executed use as the burial-transit Diabetes Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medical Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Dyseipidemia Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 X No Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who m lated carrie of ceath Item 23a) (Type, Print) 17 North Summit Ave. Tinisha Jordan D.O. Gaithersburg, Md. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar		Marylar	nd / Depa Ce	artment of tificate of					Reg. No.	nn	5	04611
Physici /Medic		Decedent's Name (First, Middle, Las WILHELMINA M.) IOWNSEN	D					E	Date of Dea Month Peb.	Day 01	, 20	rear 106	3. Time of Death
Examin	ier	4a. Facility Name (If not institution, give 205 Eighth Street			(4b. City, Town Pocomok If Under 1 Ye	ce (Date of Bird			rces	
Funeral Director		5. Social Security Number 6. Sec. 219–44–1373 Usual Residence of Decedent	M 2(2 X F	7. Age (In yrs.	96 Yrs.	Months Da		Hours Mi	n.	Date of Birt (Month, Da 'eb。 1	y, Year) 4, 1		Coun	lace (State or Forei ltry) I sylvania
Maryland 1-1 show Illied at	tor	10a. State 10b. County MD Worceste:	c		ty, Town or Lo								1	0d. Inside City Limi
with the	i Director	10e. Street and Number				10f. Zip Cod 21851					10g. Citi	izen of Wh		itry?
d within 72 hours after death with the Maryland jiene. jiene. r than "natural", or Itams 23a or 28a-f show tr than "natural", or Itams 21a or 28a-f show tr a Madical Examinet must be notified at	by Funeral	205 Eighth Street 11. Marital Status 1 Never Married 2 Married 35 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rce <i>s</i> ? 2 ⊠ No re		Was Decedent of Yes, specify 0	of Hisp Cuban,	oanic Origin? Mexican, Pu Specify:	(Specify erto Ric	Yes or No an, etc.)	•	14. Race Black, Specify:	Americ White,	
within 72 hou ene. than "natura re Medicel E	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation		(Give life.	dent's Usual Oc kind of work do DO NOT use re	ne du	on ring most of v	vorking			ind of Busi	iness/Ind	
be filed Ital Hyg Id otha svent,	Be	12 17. Father's Name (First, Middle, Last)			Homema	ker		8. Mother's N		irst, Middle,		Sumame,		
and and sm	7	Oscar Matthes 19a. Informant's Name/Relationship (7			1	ng Address (Str	eet an		Rural R	oute Numbe			tate, Zip	Code)
~ ~		Barbara Cromwell 20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from S	20b. I State	Place of Dispo cemetery, crea	Asquit esition (Name of matory or other	f place)	2/5	rnol Date /200 6		20c. Lo	ocation - C		
permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Füheral Service Licen		St.	HC	Fpiscopal 2. Name and Ad olloway 03. Linde	ddress Me	of Facility Lson F	uner	al Ho	me,	P.A.		y, MD
Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or companies, or heart failure. List only of the same of th	a Due to (or as a consector as a consector	quence of):	iv D	aying,	such as card	lac or re	spiratory a	rrest,			Approximate Interval Between Onset and Death
icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	quence of):									
The law requires that the death certificate has been signed by the attending plage? Should be detached for use as forces as the control of th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of €	al death 3	⊒Ectopic pregna ☐ Other <i>(specif</i> y						23d. Date Mont		ery Day Year
uires that signed by	by	Part II. Other significant conditions of	ontributing to de	eath but not re	sulting in the u	nderlying cause	e given	in Part I.		23e. Did t		Sec. 1	oute to th	ne cause of death? pably 4 □Unkno
The law requir cate has been si page 2 should i	Completed									24a. Wa <i>s</i> autor perfo 1 ☐ Yes		pri	or to co	psy findings availa mpletion of cause
Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	Other	26. Place of □		0/20/22		6 □Other	(Specif	iy)
ng the	Certification;	27. Manner of Death Datural Accident Suicide Could not be		th, Day Year)	28b. Time o Injury	М		at es 2 □ No		. Describe				
To the Hospital or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu		4 Homicide determined	286. Place buildii	ng, etc. (Spec	ify)	reet, factory, off.				City or To	wn, State	e) 		al Route Number,
ns Hosp n 24 hoo ne Funs bletely fi	Medical	29a. Certifier (Check only one) Certifying Ph	iner: On the ba											
To th within To th	Me	29b. Signature and title of certifier	Jan	Los).0.	29c, Lic	dense i	129	//		29d. Da	te signed	(Month,	Day, Year)
ET 6	ate	30. Name and address of person who Charles Staubs, I	0.0		rket St		oco	moke C	ity,	MD 2	1851		/,	

DHMH 17 Rev 1/2001

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day VENDRICK JAMES JANUARY 28 2006 09:35 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□F Yrs. 47 JAN. 31,1958 ANCHORAGE, 222-44-8058 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1617 PUMPHREY STREET 21224 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ▼No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER HOME REMODELING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RITA BROWER MALCOLM M. VENDRICK, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 NETHERLANDS DRIVE, MIDDLETOWN, DE 19709 CYNTHIA J. WALKER / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GRACELAWN MEMORIAL PARK 02/03/2006 NEW CASTLE, DE 21. Signatura of Fundal Strvice Landsee M01170 SPICER-MULLIKIN' FUNERAL HOMES 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 Kellet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Possible aspiration pneurionia disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Iweek Due to (or as a consequence of) aspirat I hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consquence of) CERTIFICATION APPROVED BY TIGH EXAMINER Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcohol withdrawal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

o يَ **Physician**

/Medical

Examiner

Funeral

Director

Work

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death

within 72 hours after

al Hygiene.

permit. Pages 1 and 2 should be filt Department of Health and Mental Himportant: if Item 27 is marked oth any injury or other traumatic event 2008.

Physician

/Medical

Examiner

burial-transit and

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certificate has been si rector, page 2 should

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Certification: To

Medical

Maryland 21215-0036

Baltimore,

r then "naturel", or items 23e or 28a-f ehov the Wedical Examiner must be notified at

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certificate be executed

William of Vital Records, death. l or A To the Hospital within 24 hours a To the Funerel Completely filled in

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

DEVILLE, MD CURTILAND 32. Registrar's Signature

and manner stated.

3001 SOUTH HAWOUER STREET

FEB 0 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES0001

29d. Date signed (Month, Dey, Year) January 28, 2006

BALTIMORE MD

			1 - For State Registrar	State of Maryla		artment of H		nd Mental I	Hygien		04613
			1. Decedent's Name (First, Middle, La.	st)				2. Date of	Death		3. Time of Death
	Physici /Medic		Rebecca Dian	e Wri	ght			Jan	uary	29,2006	10:50pm ^M
	Examin		4a. Facility Name (If not institution, give		-	4b. City, Town, or	Location of [Death	4	c. County of Dea	
			4515 Willard Ave			Chevy Cl				Montgom	
	Funeral		5. Social Security Number 6. S 299-44-5195	DM of Xe	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month,	Day, Yea.	r) C	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	58	113.			Dec	5,194	1 0	nio
	ytand now		10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mar.	tor	MD Montgom	erv	Chevy Ch	iase					1X1Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What C	ountry?
	23a	a	4515 Willard Ave	#1621		20815	5		Un	ited Sta	ates
	be filed within 72 hours after deeth with the Maryland tal Hygiene. id other then "natural", or items 23a or 28e-f show event, I'm Medical Exarili will rest be incillised at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin n, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whi	
3	or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: W	nite
9500-61212	thou stural		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ation		16b.	Kind of Business	/Industry
7	filed within 72 Hygiene. Ither then "nai	Completed	(Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	during most o	f working			
7	giene giene er the	mo.	Clamaritary, Sacordary (C 12)	College (1-4or 5+)	Dir	ector			Wa	sh Schoo	of Ballet
<u> </u>	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Mic			
yland	Ment Ment arkec	2	Earl William Wr	ight Jr.			Diane	e Adele .	Johns		
Mar	2 sh and Is m	U a	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number (or Rural Route Nu	mber, City	or Town, State,	Zip Code)
≥ ໝົ	es 1 and 2 should be of Health and Mental If item 27 Is marked o r other treumetic eve		Craig Earl Wrigh 20a. Method of Disposition	t/Brother	719	Shirley I	rive,I	Tipp City	,Ohi	0 45371	
<u> </u>	Pages nent of H int; if ite		1 ☐ Burial 2X Cremation 3 ☐	Removal from State	cemetery, crei	natory or other plac	θ)				
saitimore,	rtent		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 			Cremator		-2-06		11s Chur	
g	permit. Pages Depertment of Importent: If it any injury or once.		Dr. Our tres	to be		2. Name and Addres					
			23a. Part1. Enter the disease, or com	olications that caused the d						Ington L	Approximate
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	/Medical		disease or condition resulting in death)	a. Breast C Due to (or as a cons							
	Examiner		One and the Cabana distance	b							
	ნ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):						
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g		dlcal	•	d							
×	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-						23d. Date of de	livery
go.	0 0 0	Iclai	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time o		Ectopic pregnancy Other (specify)			_	Month	Day Year
j.	y th	hys	9 DUnknown	9□Unknown							
ທົ	requires that een signed b hould be deta	ру Р	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
Hecord	w requir been si should							_ 1	☐ Yes	ZNo 3 P	robably 4 Unknown
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	Th ate pag	Completed						1 ☐ Ye	erformed? s 2 X N		2 □ No
VItal	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Haspital:		Oth		Death (Check or		_	
	hys this	٦.	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier			ing Home 5 X R			cify)
	ding T. After fune	tlon	1 X Natural 5 ☐ Pending	(Month, Day Year		Work	rat ⟨? Yes 2 ∐No		be now inj	ury occurred	
UNISION	r Attender death rector:	fica	3 Suicide 6 Could not be		t home, farm, str				n (Street a	and Number or R	ural Route Number,
5	pitel or Attending Fours after death. Intel Director: After filled in by the funera	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Town, Sta		
	pire ere fille	calc	29a. Certifier 14 Certifying Ph	ysician: To the best of my h	knowledge, deat	n occurred at the time	e, date and p	place, and due to	the cause(s) and manner as	s stated.
	To the Hos within 24 hd To the Fun completely	ledical	One)	niner: On the basis of exam and manner stated.	mation and/or in	200		occurred at the tin			
	To To	Σ	29b. Signature and title of certifier			29c. License				ate signed (Mont	
	10		heye	a cupline	a 35	D543	78		F	'ebruary	1,2006
	60		30. Name and address of per vin who cheryl A. Ayles			Print) ckledge Di	rive R	ehtesda 1	MD 20	1817	
	Sta	te.	31. Date filed (Month, Day, Year)				LIVESDE	onecoua,	س ۵۰	O17	
d'	Registr		FEB 02 2	32 Registrar's Sig	B. Ap	ski)					

			for State Registrar	State of Marylan	•	artment of Hertificate of L			iene • 2000 0 6	04614
	Physicia	an	1. Decedent's Name (First, Middle, Las		,, - ÷, -			2. Date of Dea Month		3. Time of Death
	/Medic	al	Rebecca 4a. Facility Name (If not institution, give		rner	4b. City, Town, or	Location of Death	Januar	y 30, 20	
	Examin	er	Manor Care of La			Largo	Location of Death			Georges
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country)
H	Director		130-18-3643 10 Usual Residence of Decedent	□ M 2XXF 83	Yrs.			Dec. 2	, 1922	South Carolina
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Prince G	eorge's Up	per Ma	rlboro				1 X Yes 2 No
	72 hours after death with the Maryland Insture!; or Items 23s or 28s-f show Jical Examiner must be notified at	by Funeral Director	10e. Street and Number 5802 South Marwoo	al Diva		10f. Zip Code 20772			Og. Citizen of WI	,
	ns 234	eral	11. Marital Status	12. Was Decedent Ever in U	.s. 13.	Was Decedent of His	spanic Origin? (Spe			- American Indian,
9	after d	Fun	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give		If Yes, specify Cubar	Specify:	Rican, etc.)	Black	, White, etc.
003	urel',	d by	3 XWidowed 4 □ Divorced	Year or Dates:						can American
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212	d with giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurs	e			Medical	I
Maryland 21215-0036	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)
ryla	d Men narke natic	2	James Robinson	Suna Briath	10b Maili	na Address /Ctrost s	Mary J		Cibrar Town 5	State Zin Codel
Ma	ith and 2 si		19a. Informant's Name/Relationship (7) Ruby M. Robertson		1	ng Address <i>(Street a</i> South Ma			-	ooro, MD 20772
re,	itam		20a. Method of Disposition	20b. F	Place of Dispe	osition (Name of matory or other place		ate		City or Town, State
imo	Page ment c		1 🕅 Burial 2 □ Cremation 3 □ 3 4 □ Donation 5 □ Other (Specify	Removal from State	te of	Heaven	2/3			Spring, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghen. In the Marylan Importent: If item 27 is marked other than "neturel, or liems 23s or 28s-f show eny injury or other treumatic event. It a Meulcal Evani for must be notified at once.		21. Signature of Funeral Service Licen	ompson		2. Name and Addres				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory are	rest,	Approximate Interval Between Onset and Death
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687	ificate g phys as the	edicai		. d.					1/	
Вох	death certific e attending pl id for use as t	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnative birth 2 ☐ Feta	ancy al death 3	⊒Ectopic pregnancy				of delivery
Ю. В	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4 ☐ Pregnant at time of o		Other (specify)	. =		Mon	ith Day Year
Р.	acl acl		Part II. Other significant conditions of	ontributing to death but not rer	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
rds,	es be	d by						1 🗆 Y	es 2□No	3 ☐ Probably 4 XUnknown
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I Re	o _ e g	Com						autop perfor 1 Tyes	med? de	eath?
/ita	sicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Hamitali		0.4	26. Place of Death			
of	Phys this ral di	٠ <u>.</u>	1 Yes 2 X No 27. Manner of Death		ER/Outpatie		44 Nursing no		ence 6 Othe	
	Attending I or death. ector: After by the funer	ation:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	<br Yes 2 □ No		,,	
Division	of or Attendial after death. Director: A din by the fu	Certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	e Hospitel or Att 24 hours after de 6 Funerel Direct letely filled in by t	ledical C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at the tim	ne, date and place, pinion, death occurr	and due to the c ed at the time, c	cause(s) and mar date and place, a	nner as stated. .nd due to the cause(s)
	To the Hos within 24 ho To the Function	Me	29b. Signature and title of certifier			29c. License			-	(Month, Day, Year)
)	5) AXVVV	mo)		D 51	520		Januar	y 31, 2006
			30. Name and address of person who Bahram Pishdad	completed callse of death (Ite , M.D. 1328 S	m 23a) (Type outher	n Ave. St	e. 301, V	Vashingt	con, D.C	. 20032
	. Sta Registi		31. Date filed (Month, Day, Year) FEB 0 2	32. Redistrar's Sign	ature /	Goods				

		For	State of Man	yland / Dep	artment of H	lealth and	Mental Hy	giene,	m pro pro	~1 ~	1 1
		1 - State Registrar		Ce	ertificate of	Death		Reg. No.	J U 6	U46	15
Physic /Med		Decedent's Name (First, Middle, La William Leroy		Jr.			2. Date of De Month	4 a	2,00	-	32 ÅM
Exam	iner	4a. Facility Name (If not institution, given by the stering of the	Geneval	Hospital		or Location of Deat	2 -3	40.0	County of Deatl	- 1	,
Funera	al	5. Social Security Number 6.3	Sex 7. Age (/	In yrs. last birthday) If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th Vear	9. Birtl	hplace (State untry)	or Foreign
Directo		219-46-3933	1 ⊠ M 2□F	58 Yrs.	Months Days	Hours Min.	June 1		1	ryland	
land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation					10d. Inside	City Limits
Many a-fsh	ctor	MD Dorche	ster		Linkw	ood				1 □ Ye	2 No
with the or 28	Director	10e. Street and Number 3604 Bonnie I			10f. Zip Code	21025		10g. Citiz	en of What Co	untry?	
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Ite; INITY INITY INITY IN TAILS SOURCE STEEL GEATH with the Maryland A health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "neturel; or Items 23e or 28e-f show other treumatic event, I'm Walted Engle, and market colling and	by Fun	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No		io Rican, etc.)		Black, White Specify: W	nite	
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Mar d 2 sh th and 7 is m treum	Y	19a. Informant's Name/Relationship Lillie Warfield	Турө, Print) Wife		ling Address <i>(Street</i> 1 Bonnie 1			-		(ip Code	
s 1 and 27 tem 27 other tr		20a. Method of Disposition			position (Name of ematory or other pla		Date 1		1835 ation - City or	Town, State	
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Daltimore, permit. Pages 1 an Department of Heal Importent: if item 2 eny injury or other	ouce.	21. Signature of Funeral Service Lice	nsee		22. Name and Addre					P.A.	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Marylin P. Amato 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square dale Hospita Se Ba Itim ore 0 ranklin | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Formannia) | Months | Days | Hours | Min. | April 16, 1923 | Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months 82 213-18-2307 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Iteme 23e or 28e-f show traumatic event, the Macical Examinar count on notified at 1 Yes 2 No Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Ave. 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AF No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. I limportant: If Item 27 is marked other than "natural", or Item eny Injury or other treumatic event, the Medical Expense. 1 ☐ Never Married 2 ☐ Married Hnlæto Mary lill Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail - Hahn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Nancy Workman ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deserie Stroup /granddaughter 2106 Graythorne Road Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place)
MostHolyRedeemer 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/20/06 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part 1. Enter the disease, or combinations that caused the death. If no net enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 17079 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclen a for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown HERNIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 Yes 1 Yes 2 12 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 No his After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aua 2 250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive, Baltimore 9000 Mr. Sabing fara Z Franklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2006

Registrar

FEB 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 10:15 AM Dlair 10 -2006 /Medical Eacility Name (If not institution b. City, Town, or Location of Death 4c. County of Death give street and number) Examiner 8. Date of Birth (Month, Day, If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 216-54-6977 Days Months Hours 1 M 2□ F 54 m_D Director Usual Residence of Decedent with the Maryland City, Town or Location 10d. Inside City Limits 10a State 10b. County 10c rthan "natural", or Itame 23a or 28a-f ehow the Medical Examiner must be notified at ndallstown 1 Yes 2 0 Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and No 21133 arriage be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 D Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use regired) 15. Decedent's Education (Specify only highest grade completed) 16b. Mind of Business/Industry Nor College (1-4 or 5+) Elementary/Secondary (0-12) nspector man other Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be and Mental 27 is marked of traumatic ever taams Mitred Pages 1 and 2 should ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3518 Carriage Hill Cir. Tl, Randallstwn, M)
cant Disposition (Name of 19a Informant's Name/Relationship (Type, Print) or other tre 6wn, MD 21133 hona D Method of Disposition

1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory permit. Pages
Department o
Important: If
any injury or
once. 7/2006 Owings Mills 4 □Donation 5 □ Other (Specify) sarrison tores 21. Signature of Fune a Service License 8728 Liberty Rd. Randallstown, mi 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hepatitis months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine sate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 € Cinknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 22 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) +05pice 1 ☐ Yes 2 No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) : After thi 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A d in by the fu investigation 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funstral Direct completely filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D24170 80 MD February 10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice 838 Eutaw St Baltine, MD E. TSO MD

State Registrar

DHMH 17 Rev 1/2001

FEB 1-7 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 💍 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle_Last) Month Physician Year February ATRICK 135 AM 2006 HLLEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Baltimor sarrari ran 2000 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 10M 20F Yrs. MARYLAND 216-10-507 Director 7/19/7 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehov empt injury or other traumatic event, the Madical Examment intermetical anone. 1 Yes 2 No BALTIMORE **Funeral Director** mo MARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code AUS USA 2502 1 AYLOR 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married Tes 2 No 1 Yes 2 No Specify: WHITE Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN STEEL BETHLEHEM 12 DVISON 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HLLEN ECELIA REDERICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SPOUSE BERNADINE E, MD 21234 MYLOR 20b. Place of Disposition (Name of cometery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY EVANS FO 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 15,2006 FOREST 22. Name and Address of Facility EVANS 21. Signature of Fun Service Licensee UNERAL CHAPEL RD PARKUILLE HARFORD mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Brain /Medical Due to (or as a consequence of): Examiner orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Be Completed by Physician/Medical Examiner attending physician and for use as the buriel-transit l or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 X Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter de To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Hassan 31. Date filed (Month, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 LOC 32. Registrar's Signature Baltimore

2006

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RESODO

Blud.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** YUNHOD 11:32 AM BURNSIDE February 12 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Itospital Balknore Baltimore NA atu If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1₽M 2□F Director 143.30.8095 06.06.1940 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits or 28a-f shov other traumatic avent, the Medical Examiner must be notified at 1 KYes 2 No Director NA BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 2903 OAK HILL AVENUE 21217 U8A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FACTORY MACHINI81 12/11 GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be fi Mental H permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 is marked any injury or other traumatic averages. and Menta THOMASINA BURNSIDE JAMES BURNSIDE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2903 OAK HILL AVE. EARLENE BURNSIDE WIFE BALTIMORE, MO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 02.21.06 OWINGS MILLS, MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licenanghn 5151 BALTO, NATE PIKE, BALTO, MO 23a. Part1. Enfauthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocard disease or condition resulting in death) Acula /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown cate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Monknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 PER/Outpatient 3 DOA 1 Inpatient his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 PNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 T Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 1 0 1 29b. Signature and title of certifier

0

Burnside

21215-0036

Maryland

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) State Registrar

MAHAJABIN

32. Registrar's Signature

Mb.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALI

2

2006

IM.A.

29d. Date signed (Month, Day, Year)

12, 2006

21515

February

2401 West Belvedere tre, Baltimore, Maryland

State of Maryland / Department of Health and Mental Hygiene 04620 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16,2006 **Physician** Month Belcher James February 2:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Dundalk 3116 Shortway | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 13, 1930 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F 214-36-1927 Yrs Director 75 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Inside City Limits Maryland Baltimore Dundalk 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3116 Shortway 21222 USA filed wifhin 72 hours after deeph Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No δ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years MNCPPC event, If Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be Department of Health and Menfal marked Hicks F. Belcher 27 is marked traumatic e Daisy Lee Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Of Health a: If item 27 is Mary Belcher wife 3116 Shortway, Dundalk, MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) February Park Lawn Memorial important: I eny injury o 20, 2006 Rockville, Maryland 21. Signature of Funeral Service Licenses. 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. once 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician GASTRIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thef the death certificate be executed the burial-transif Due to (or as a consequence of): Box 68760, physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ö Month Year 4 Pregnant at time of death 5 Other (specify) P.O. been signed by fhe a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: Affer this certificefe has completely filled in by the funeral director, page 2: 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manger of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural Injury 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD D16619 Congain Soars 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARY-SOARES 9940 FRANKLIN SQUARE DR. BALTIMORE, MO. 2/236 31. Date filed (Month, Day, Year) 32. Regultrar's Signature State 2006 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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Examir	ner	4a. Facility Name (If not institution,				-		Location of	Death			County of	Death	
		Johns Hopkins - 5. Social Security Number		7. Age (In yrs.	last birthdav)	If Under	Ltimo	re If Under 24	Hrs. 8	. Date of Birt			9. Birtho	place (State or Fo
ineral rector		175–20–1737 Usuat Residence of Decedent	1□ M 21 F		31 Yrs.	Months	Days	Hours	Min.	Date of Bird (Month, Da Cotembre	y, Year) 2 3,1	924 O	couir bnÉli	uence, PA.
Mot		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	10d. Inside City Li
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3a or 2l	al Dire	10e. Street and Number 7818 St. Patric	ia Lane			10f. Zip	212	22			10g. Citiz	en of Wh JSA	at Cour	ntry?
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Important: If Its any Injury or ot 2008:		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		.00						ne Of Road,				
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DHMH 17 Rev 1/2001

		1 - For State State Registrar		rtment of Health and I tificate of Death	Reg. I	.000	04622
Physi	cian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Med		Ruth Ann Brown			February	8, 20	
Exam	niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	٠ ١	4c. County of Dea	
Funera	1	Berlin Nursing Home 5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	Berlin If Under 1 Year If Under 24 Hrs.		Worces 9. Bir	thplace (State or Foreign ountry)
Directo		214-30-9150 ^{1□M 2} √F	74 Yrs.	Months Days Hours Min.	(Month, Day, Yea Dec 6, 19		ryland
pu .		Usual Residence of Decedent	10c. City, Town or Loc	cation			10d. Inside City Limits
Aanyla f sho	ō	MD Worcester	Berli				1 ☐ Yes 21 No
the N	Director	10e. Street and Number	Delli	10f. Zip Code	10g.	Citizen of What Co	
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ems ?	Funeral	11. Marital Status 12. Was Decedent Ev. Armed Forces?	er in U.S. 13. V	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
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21215-0036 ad within 72 hours aff giene. er than "natural", or than Medical Every		15. Decedent's Education	16a. Deced	ent's Usual Occupation	16b.	Kind of Business	/Industry
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lore, Marylages 1 and 2 should to f Health and Meril item 27 is marka or other traumatic		20a. Method of Disposition	20b. Place of Dispos			Location - City or	Town, State
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		23a. Part Enter the disease, of complications that caused the shock or heart failure. List only one cause on each line.	ne death. Do not ente	er the mode of dying, such as cardia	or respiratory arrest,		Approximate
Physicia	n e	Immediate Cause (Final disease or con titon		iraton Feelure	ure		Interval Between Onset and Death
/Medica	al	resulting in death)	consequence of):	7			Moulus Y Cous
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O. I the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tir 9 ☐ Unknown 9 ☐ Unknown	me of death 5∐	Other (specify)			,
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Div To the Hospital or within 24 hours afte To the Funaral Div completely filled in b	edical C	29a. Certifier (Check only one) Medical Examiner: On the basis of e and manner state	examination and/or inv	occurred at the time, date and place restigation, in my opinion, death occurrence.	e, and due to the cause arred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and letter of certifier		29c. License number	29d.	Date signed (Mgn	th, Day, Year)
•		11/ Vollteele	an	2 100016	(7/7/	06
						- Appendix	a graph I I
11		30, N. e and address of person who completed cause of dea //// / R. Date filed (Month, Day, Year) 32. Registrar FFR 1 7 2006	dulie,	D2876	exted Hafice	Few.	e 17744

Brown, Ruth

State of Maryland / Department of Health and Mental Hygienie Certificate of Death 2. Date of Death 3. Time of Death 8:25 AM **Physician** 2006 /Medical 4b. City, Town, or Location of Death **Examiner** Raltmore Hunder 24 Hrs. 4309 les ville Ke 090 Birthplace (State or Foreign Country) Social Security Number Age rs. last birthday, If Under 1 Year **Funeral** Days Hours Min 38-364 6 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event. It is Medical Examinar must be notified at Baltimore 1 | Yes 2 | 100 Funeral Director 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Items 23a or 4309 2120 ven Koad 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Yes 2 No þλ 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 90llege (1-4or 5+) other than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Importent: If tem 27 is marked other
any injury or other traum...... 17. Father's Name (First, Middle, Last) Molher's Name (First, Middle, Maiden -iscoe erome 19a. Informant's Name/Relationship (Type&Print) 19b. Mailing Address (Street and Number or Rural Route Number, 21208 20a. Method of Disposition 20c. Location , City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 5 Ditter (Specify) 21. Sign yure of Funer 23a. Part1. Enter the shock, or heart disease, or complications that caused the death. failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, lary, leading to min ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dualto for as a ponsequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably icate has been sig r, page 2 should b 2 🗆 No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death | Check only one examiner Other: 1 ☐ Yes 2 No 1 Inpatient 3 DOA Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or At within 24 hours after or To the Funeral Direct 4 | Homicide 29a Certifier 1. Certifying Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D19607 (Item 23a) (Type, Print) NOEL E. MECALL 2433 LINDA LANE JARRETTSVILLE, MB. 2108 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar 2006

		•	For State Registrar		State of N	/larylar		artment rtificate					giene Reg. No.	\cup \cup \cup	•	14624
	10 10		1. Decedent's Name (First, Mi	ddle, Last)								2. Date of Dea				3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institu				LUCIOL	4b. City, To		Location of		1 001 001		County of		7.50 an
400			Gloria Friend	de Aes	I betsis	ivina		Essex					Ba	altim	ore	
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	2		Usual Residence of Decedent													
	urylar show	_	10a. State 10b. Cou	nty		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Limits
	9 Mg	Director	Maryland Bal	Ltimon	re	Mid	dle Ri	ver								1 Tes 2 No
	if th	Oire	10e. Street and Number					10f. Zip C	Code				10g. Citi	zen of Wh	at Coun	itry?
	23a		2209 Firethor					212						S. A.		
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Maryland	should by nd Menta marked imatic ev	은	Carl David 19a. Informant's Name/Relation		ford, Sr	•	19h Maili	na Address /	Street			Elzey	r City o	r Town S	tate Zin	Code
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100		<u>.</u>	Sequentially list conditions,	b	Due to (or	as a consec	nuence of):								-1-	
	ted nslt	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	220 10 (01	4 0011300	1201100 017.									
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9 x	The law requires that the death certific ite has been signed by the attending p tage 2 should ba detached for use as	Physiclan/Me	IF FEMALE:	2	3c. If yes, outcor	ne of prean	ancv							22d Data	of dolars	
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1 1	Sta	ete.	31. Date filed (Month, Day, Y	ear)	A. Req	istrar's Sign	ature #	* AF =			1-0	-,, -, -	14	*****		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Jean Barner A^{M} 2006 7:30 February 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Examiner Joppa 342 Trimble Rd 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 21XF 66 Yrs. Director 253-56-2147 1939 July 30, Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Medical Exactions must be notified at Director 1 ☐ Yes 2 XNo Harford Joppa Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21085 342 Trimble Rd. or Items 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White Specify: "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Eliza White William Thomas Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 s Department of Health ar Important: If itam 27 is any in ury or other trau QDG9. 342 Trimble Rd., Joppa, MD 21085 Robert A. Barney/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-16-06 Towson, Maryland 21. Signalure of Funeral Service 2 McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the yearh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARNOST immediati /Medical Due to (or as a consequence of): Examiner CHRONIC RENAL FALLURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed CORONARY ARTERY DISEASE attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 HUPERTENSION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ N100m 1 Yes 2 No 3 Probably 4 Unknown Completed MIGRANE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate OSTEDNENIA 2 No 1 Yes 2 No 1 ☐ Yes Division of Vital the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA his h 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ hours after 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo D4/496 2/14/06

ath (Item 23a) (Type, Print)

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ressignature Saba Siddigs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABA SIDDIQI 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 06626 1 - Stata Ragistrai Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Louis February 15, 2006 Battaglia 4:22 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2602 Liter Court Ellicott City Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 219-18-5650 Yrs. 79 Director 09/28/1925 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner nust be notified at Howard Ellicott City 1√2 Yes 2 🗖 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2602 Liter Court 21042 USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑l'Yes 2 □ No If Yes, Give Year or Dates: 1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò Specify: White 3 ☐ Widowed 4 ☐ Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) Owner Lou's Poultry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosario Battaglia Josephine Farace ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 Liter Court, Ellicott City, MD 21042 Madeline Battaglia / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages of Popartment of Himportant: If its any injury or ot once. 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Loudon Park Cemetery | 02/18/06 Baltimore, MD 21. Signature of Funeral Service Licensee L. Kaufman Funeral Home at MMP, Inc. Washington BLVD Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the shock, or heart failure. List only one cause on each Le. Approximate Interval Between Onset and Death de of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (o Examiner The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a con Box 68760. Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. | the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has be page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: in 24 hour.
the Funeral Directory filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the best of my moviedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier 1 Cartifying Physician Medical 2 Medical Examiner: O (Check only one) within 2 To the I the e 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 30. Name and address of person who completed caus X MD 7600 Osler Drive, Suite 411, Towson, MD 21204 Ayman F, Akkad, 31. Date filed (Month, Day, Year) State Registrar

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		Examin	ier	4a. Facility Name (If not institution, give EASTPOINT A	JUFSNG T	toME		4b. City, Town, or BATIM	DRE, M.	5	4c. County	of Death	MORE
		Funeral Director		5. Social Security Number 6. S 228 - 30 - 1601		e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth Cou	place (State or Foreign intry) VA
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		Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ptic		ia					1 we e)
1.33.53		Examiner			Due to (or as	CV		dec - 5	tus c	elcer			2 1 05
5	7	Sit ad	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence		,					(), - 5
8	٧	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence		+ 4					6 Mg2
5	8760	icate be executed physician and s the burial-transit	dicai E		dV	as c	mla	ir D.	emen	tik			1 year
2		n certifica Inding ph use as th	(d)	IF FEMALE:	220 Hunn nutrama	-1							
5	Вох	leath c attend	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)				te of deliv nth	very Day Year
7	P.O.	at the c by the	Physician/M	1 □ Yes 2 ØM6 9 □ Unknown	9□ Unknown								
	ds, l	ires this signed If be de	by	Part II. Other significant conditions of	ontributing to death but	***			e SSion	of the	obacco use cont Yes 2□No	ribute to	the cause of death?
,	Records,	w requ	ompieted	- Devision -	19 124	<u> </u>	0017	acpr	~)) (U N	24a. Was			opsy findings available
S	l Re	The la ate has page 2	omo							autor	osy ormed?	prior to co death? I Yes	ompletion of cause of
7	Vital	ician: certific ector,	BeC	25. Was case referred to medical examiner?	Hospital:			04-	26. Place of Death				
-	of	Phys er this eral dir	n: To	1 Yes 2 No	28a. Date of Injur	y 28t	Outpatient D. Time of	3 DOA Other	4 Loursing Hor		dence 6 Oth		ify)
'W	sion	ending sath. or: Afte	atio	1 Accident 5 Pending Investigation		Year)	Injury		? es 2□No				
	Division	or Att after de Direct in by t	ertification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, :. (Specify)	, farm, stre	et, factory, office		28f. Location (: City or To		er or Rui	al Route Number,
		To the Hospitel or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	0	29a. Certifier 1 Certifying Ph	ysicien: To the best oniner: On the basis of	of my knowled	dge, death	occurred at the time	e, date and place, a	and due to the	cause(s) and ma	inner as	stated.
		o the H ithin 24 o the F omplete	Medical	29b. Signature and title of certifier	and manner sta	ted.	and or my	29c. License			29d. Date signe		
		± ≽ ± 00		M. nor	reloven	n	9	D4	575	7	Feb	14	2006
		1		30. Name and address of person who			a) (Type, F	Print)	Sa ato.	Λ.	, R.1	+ 1	10 21224
		Sta	ite	31. Date filed (Month, Day, Year)	1				C 0- > 10-1	rn MV	U D4	TE , (6	av v.zct
		Registr	ar	FER 1 7 200	16 Marie	ar's Signature	19						

7

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) FEB 1 7 2006

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Karan Hudhud



86

February 13,2006

and

		ŕ		partment of Health and leartificate of Death		ene 006	04629
4	Physici /Medic	- 15	Decedent's Name (First, Middle, Last) Jennie Rosemary Coppolino		2. Date of Death Month February	15, 2006 Year	3. Time of Death 9:45PM M
	Examin	3.6	4a. Facility Name (If not institution, give street and number) Morningside House	4b. City, Town, or Location of Deat Baltimore		4c. County of Dear Baltimor	e
W	Funeral Director	Į.	5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthda 88 Yrs. Usual Residence of Decedent	Months Days Hours Min.			thplace (State or Foreign ountry) Oona, PA
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Maryland Baltimore Perry				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Director	10e. Street and Number 8800 Gerst Avenue	10f. Zip Code 21128		g. Citizen of What Co	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinant must be rectiled at ADDE.	by Funerai		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
Baltimore, Maryland 21215-0036	d within 72 ho plene. r than "natur ine Medical i	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of wo a. DO NOT use retired) ice Clerk	rking	Waverly	/Industry
land;	uld be filed dental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Patsy LaBue		me (First, Middle, Ma Randazzo	aiden Sumame)	
, Mary	and 2 sho salth and h n 27 is ma or trauma	. 4	last to a war and the contract of the contract	ailing Address (Street and Number or Ri 800 Gerst Avenue	Perry Hal	1, MD 211	28
imore	Pages 1 ament of He ent: If Iten ury or oth		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donatign 5 □ Other (Specify) Gardens	of Faith Cem. 02/1	.8/2006 B	oc.Location-City or altimore,	
Balt	permit Depart Import any in		1104/	5305 Harford Road Balt	imore,Maryla	and 21214	
)	Physician /Medical Examiner)r	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	enter the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e ettending physicien and nd for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.				
P.O. Box 6	death certif e ettending ad for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
	sign sign d be	ρ	Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I,			o the cause of death?
al Reco	The law ate has t page 2 s	Completed			24a. Was an autopsy perform	24b. Were a prior to death?	utopsy lindings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	tient 3 DOA Other: 4 Nursing I e of 28c. Injury at Work? M 1 Yes 2 No	ath (Check only one) Home 5 Resider 28d. Describe hov 28f. Location (Street City or Town,	oce 6 Other (Special Vinjury occurred	3
Ω	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical Ce	29a. Certifler (Check only one) (Check only one)	eath occurred at the time, date and plac r investigation, in my opinion, death occ	e, and due to the cau	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and tiple of certifier	29c. License number		d. Date signed (Mon	
1/	2		30. Name and addless of person who completed cause of death (Item 23a) (Ty Nobel Person & SLOT Lichkevien B7 V.	pe, Print) & GSH Prof Bulding #	303 Balt	more MD	2/239
±.	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 7 2006	& GSH Prof Building to			

Amen item#8, perith; 633,3/13/06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** February 13 2006 917 PM eonaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Baltimore Sinai If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 11/27/1921Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth, (Month, Day) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Days 84 263-24-275 Director 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f shov 27 is marked other than "natural", or Iteme 23a or 28a-f sho traumatic event, the Modical Examinar must be motified at 1 ☐ Yes 2 No Completed by Funeral Director 1Kegu 10e. Street and N∎mber 10f. Zip Code 10g. Citizen of What Country? 820 Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumetic event, the Medical Examinat. ans. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working rife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry dary (0-12) College (1-4or 5+) arpent 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, To Be Belton had of Disposition Burial 2 Cremation 3 Removal from State 1 Burial 2 □ Oremano.
4 □ Donation 5 □ Other (Specify) 21. Signature of Fur a al Servica Lice seg MD 21133 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrythmia Cardiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Honknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 1 🗆 Yes 2 No 2 No Division of Vital 25. Was case releffed to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 *ER/Outpatient 2 1 Inpatient 3 DOA 28b. Time of Injury 27. Manner 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054482 February 13, 2006 eted cause of death (Item 23a) (Type, Print) West Belvedere Ave Baltimore, MD 21215 Patrick M binley 2401

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician 55/M 2006 Lebruar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Pikesville Care of Health Kuxton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Country) Ball Twole, MD Social Security Number 6. Sex **Funeral** Days Hours 1□M 2XF 220-32-313 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Examiner must be notified at Pilesville 1 Yes 2 No Baltimore Be Completed by Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What, Country? 21208 2821 or Itams 23a Load Unit Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other the any injury or other traumatic event, Its Once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oleski atherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Upland Road Unit J5 Baltim Oct, MD; 21210 19a. Informant's Name/Relationship (Type, Print) Koad Upland Bradley Dorald 6 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Evans Funeral 21. Signature Name and Address of Facility attives Funcial + Cremation Ctr. P.A. MD,21093 enter the disease, or complications that caused the or heart fallere. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the deats Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ZHEIMERS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Year Month 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uaknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2P No 2.2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2. No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by within 24 hours after To the Funeral Direct 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28595 16 06 Meller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		giene Reg. No.	06	04632
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Beverly June Cabezas	Month	15	Do	6:25AM
	Examin		4a. Secility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. Co	unty of Death	
-			Franklin square Hospital Lenter Hostelale	1		WHIM	10re
	Funeral Director		5. Social Security Number 6. Sex 1 M XXF 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Dec. 8	h y, Year) 1053	Cour	
			Usual Residence of Decedent	Dec. o	, 1900	Mary	<u>tanu</u>
	h the Maryland r 28a-f ehow Lnottiled at		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Ba-f.e	cto	Maryland Baltimore Middle River				1 Yes XX No
	with th	Dire	10e. Street and Number 65 Henderson Road 21220		10g. Citizer	of What Cour	itry?
3	deeth with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director		ecify Yes or No-		Race - Americ	can Indian.
7710	uffer d	Fu	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 文⊠ No	Rican, etc.)		Black, White,	
200	72 hours after natural', or ite	Completed by	3 ¼ Widowed 4 □ Divorced If Yes, Give 1 □ Yes XX No Specify:		Sp	^{recify:} Wh	ite
250	n 72 h	iete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind	of Business/In	dustry
702	y within jiene. r then "	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Records Keeper		Med:	ical	
o √2	filed Hygi ther int.	ပိ	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,			
		To Be	Elton Engle Rea Ruby In	ez Smitl	h		
ary	d 2 should th and Men 7 ie marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run				•
S Z	s 1 and 3 f Health item 27 other to		Ruby Rea (Mother) 6903 Birdwood Avenue,				
30	Pages 1 nent of H int: if ite iry or otl		1 Burial 2 Cemetery, crematory or other place)	Date		ion - City or To	
altim	it. Pa trimer triant njury		4 Donation 5 Other (Specify) 21. Signature of Funeractory ice Licens 9 22. Name and Address of Facility 1.				
Ba	permit. Pages Department of important: if it eny injury or c		21. Signature of Funeral Sevice Licens e 22. Name and Address of Facility Bruzdzinski 1407 old Eastern A	Funera. Venue. 1	l Home Essex	e, P.A. Marvl	and 21221
		7	23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock of heart failure. List only one cause on each line.			7	Approximate Interval Between
	Physician		Immediate Cause (Final				Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):				7043
	Examiner	L.	Sequentially list conditions, b. Sepuls			1	taays
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events			1	+ Mus
<u>~</u>	execunand and al-tra	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):				rungs
68760,	icate be executed physicien and the burial-transit	edical	d				
	rtificate ng phy: as the	Medi	IF FEMALE:				
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		230	I. Date of delive Month	ery Day Year
P.O.	he de the a	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown 5 ☐ Other (specify)				,
	that the ded by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use	contribute to the	he cause of death?
Division of Vital Records,	quires n sign uld be	d by		101	Yes 2 1	No 3 ☐ Prot	pably 4 Unknown
000	aw rek s bee 2 shor	Completed		24a. Was	an 2	24b. Were auto	psy findings available
2	The la	E			rmed?	death?	mpletion of cause of
/ita	cian: ertifica ector,	Be	25. Was case referred to medical examiner?				
of `	Physic this c	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Ho	ome 5 Resid			y)
uo	ding I h. After funer	tion	27. Magner of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation (Month, Day Year) M M M 28b. Time of 28c. Injury 28b. Time of 28c. Injury 28c. Injury 28b. Time of 28c. Injury 28c. Injury	28d. Describe h	now injury o	ccurred	
i <u>s</u>	Atten r deat octor:	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			lumber or Rura	al Route Number,
ρi	ei or s s efter of in b	Certification:	4 Homicide building, etc. (Specify)	City or Tov	vn, State)		
	To the Hospitel or Attending Physician: The law requires that the death certifi within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the	cause(s) an	d manner as s	tated.
	the H hin 24 the F	Medical	one) and manner stated.				
	To To		29b. Signature and title of certifier 29c. License number	1	O 2	signed (Month,	
	25		30. Name and address of person who concluded cause of death (Item 23a) (Type, Print)		0-1	15,0	10
•	1		DR. Mehamed YASSIN 9000 FRANKLIN SCHARE DR. BA. 31. Date filed (Month, Day, Year) 32 Degistrar's Signature	ITI MOR	3 M	1212	37
	Sta		31. Date filed (Month, Day, Year) 32 Jegistrar's Signature				
- V	Registr	21	LER I (/ 110h ROTE a ROCKETZ-F				

1 _ For

CARTER, BERNARD

			1 - For State Registrar	State of M	Marylar		artment of H		d Mental Hy	giene Reg. No	000	04633
			1. Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Death
	Physici		Bernard	С.		Cart	0.10		Februa.	vu 12	14 2006	5 12:05 AM
	/Medic Examir		4a. Facility Name (If not institution, give		ər)	Cart	4b. City, Town, or	Location of D		// T	County of Deat	
	CXAIIII	iei	St. Agnes Healt		,							
	E. manual.		5. Social Security Number 6. Se		Age (In vrs.	last birthday)	Baltimon If Under 1 Year		Hrs. 8. Date of Bi		V/A	nplace (State or Foreign
	Funeral Director			© M 2□F		Yrs.	Months Days	Hours N	lin. (Month, D	ay, Year)	Co	un <i>try)</i>
			Usuel Residence of Decedent		60				Nov. 23	3, 19	145 Mar	yland
	land ew		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. fnside City Limits
	Mary 1	ō	M1 1 27/A									1 ☐ Yes 2 ☐ No
	28a	Director	Maryland N/A 10e. Street and Number		Bal	Ltimore	10f. Zip Code			10a Cit	izen of What Co	unta/2
	with	ă								rog. Cit	IZBITOT WITAL CO	unity?
	23	ral	444 Ramdom Road	10 111 - 5			21229				ISA	
	er de	L L	11. Marital Status	12. Was Deceder Armed Force	s?	1.5.	Mas Decedent of H f Yes, specify Cuba	ispanic Origin: in, Mexican, Pi	(Specify Yes or No uerto Rican, etc.)	0-	 Race - Ame Black, White 	
36	s eff	Ϋ́	1 ☐ Never Married 2 ☐xMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐Xes 2 [If Yes, Give			1 ☐ Yes 2 No	Specify:			Specify: Wh	ito
8	ilied within 72 hours efter deeth with the Maryland Hygiene. yther than "natural", or itama 23a or 28a-f ahow yth, the Medical Exama ar must be codified at	Completed by Funeral		Year or Date:	«Vietn					1		
Ŕ	n 72	lete	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usuaf Occup kind of work done	during most of	working	16b. K	ind of Business/	ndustry
2	Method Page 1	ם	Elementary/Secondary (0-12)	Coflege (1-4d	or 5+)	ше.	DO NOT use retired	")				
N	led v lygie her t		12			Carp	enter				ome Impi	covement
Baltimore, Maryland 21215-0036	be fi	Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle			
$\frac{1}{8}$	should and Men a marke umatic	၉	Robert Lee		Cart			<u>`</u>	<u> </u>	Ε.	Brock	
<u>a</u>	permit. Peges 1 end 2 should be liled within 72 hours elter deeth with the Marylan Department of Heelth and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show many righty or other traumatic avant, the Medical Examt at must be confilled at once.		19a. Informant's Name/Refationship (7			1			Rural Route Numb			ip Code)
2	of Heelth au Itam 27 in other trau		Helen P. Carter (Wife)		1.00		d., Ba	ltimore,	MD 2	1229	
Se	of He		20a. Method of Disposition	D		Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Lo	ocation - City or	Town, State
Ĕ	Peges nent of l int: if it		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		10	-	k Cemete	1	/16/06	R-11	timoro	Maryland
₩.	permit. Departmimportal		21. Signature of Funeral Service Liver	534	Dou.	22	. Name and Addres	ss of Facility T	Loudon Pa	rb Fi	inore,	lomo
ä	Departing on it								, Baltime			
			23a Part . Enter the disease, or comp	olications that caus	ed the dear						rm 2122	Approximate
			shock, or heart failure. List only of immediate Cause (Final	one cause on each	ine.			,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Acut	e My	locardia Irtery	into	rction			11 days
	Examiner			Due to (or	as a consec	quence of):	/	101.				/
			Sequentially list conditions,	b	orono	ingh	rtery	Pise	ase			verrs
	p ii	Ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consec	quence pt):	J					
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Ö,	ien urial	Ē	rosulting in south, cast	Due to (or a	as a consec	quence of):						
8760,	Attanding Physician: The law requires thet the death certificate be executed in death. sctor: After this certificate hes been signed by the ettending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit.	dical	•	d								
9	ng p	Med	fF FEMALE:									
ô	eath certific ettending p for use as	an/I	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregna		Ectopic pregnancy				23d. Date of deli	
Э.	dea ne et ad fo	20	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of o		Other (specify)				Month	Day Year
Ö	that the de ned by the e deteched f	Ę	9 Unknown	9LI Onknown	1					-		
Division of Vital Records, P.O. Box	res the igned be det	by Physician/Me	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ĕ	quire n sig uld b								_ 10	Yes 2	□No 3 Pro	babiy 4 Dunknown
၀	w require been sign should b	Completed							24a. Was	an	24b Were au	opsy findings available
æ	The law cete hes page 2:	Ę							- auto		prior to death?	ompletion of cause of
ਰ	ilcian: Th certificate rector, pag		77.5						1 Yes	2 🗆 No	1 Yes	2 □ No
₹	ilcial certii recto	Be	25. Was case referred to medical examiner?	Hospital:			Othe	200	Death (Check only			
5	Phys this al dii	은	1 Yes 2 No	1 A Inpa		ER/Outpatien		4 Nuisin	g Home 5 ☐ Res			ufy)
Ē	ing I	Ö	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Ir (Month, I	Day Year)	28b. Time of Injury	Worl		28d. Describe	how infur	y occurred	
S	eath for: /	cat	2 Accident investigation 3 Suicide 6 Could not be	.		ļ <u></u>		Yes 2 □ No				
≥	irect irect	Certification;	4 Homicide determined	28e. Place of	Injury - At h etc. (Specia	ome, farm, str	eet, factory, office		28f. Location (City or To	Street an	d Number or Ru	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.											
	108p 1 hou 1une 8ly fil	cal	(Check only 2 Medical Exam	ysician: To the bearing: On the basis	st of my kno	owledge, death	occurred at the time	ne, date and pl	ace, and due to the	cause(s)	and manner as	stated.
	To the hwithin 24	Medical	Uney	and manner	stated.							
	ot sign of the si		29b. Signature and title of certifier	2	1.5		29c. License				te signed (Month	
	. \		Ev. Ryd 2h	n. /l	10		Doo	5614	-3	21	13/2	006
	かなし		30. Name and address of person who o	ompleted cause o	f death (Iter	m 23a) (Type,	Print)					
	7		W. RAYMOND ZHU	, DEPT 1	PATHO	LOGY :	ST HGNE	s Hosp	ITAL , 90	0 Ct	ATON A	VE. BALTIMO
	Sta	te	30. Name and address of person who of W. RAYMOND ZHU 31. Date filed (Month, Day, Year) FEB 1 7 2	32. R	strar's Signa	ature						MD2/22
	Registr	ar	FERT 45	006	Esia	S. A	me					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiepe 🛭 🗍	6 04631
Certificate of Death	0 0 0 0

Physicia /Medic

Examin

Funeral Director

permit. Pages 1 and 2 should be tited within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other treumetic event, if a Medical Examinar must be notified at option.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funstal Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	- negistiat					imouto	0, 004			Heg. No				
in al	1. Decedent's Name John Ric								2. Date of D Month Februa		Š7 2	2006	3. Time of 1:45	Death Рм
ar er	4a. Facility Name (If	n, give street and nun	4b. City, To	4c.	County	of Death	.1							
	St. Agnes	Hospi		last birthday)	Balti If Under 1	more Year If Un	der 24 Hrs.	8. Date of B	N/.			/ == ,		
	214-30-74		XXM 2□F	72	Yrs.		Days Hou		(Month, D	ay, Year)	934	Ohio	place (State or ntry)	roreign
	Usual Residence of			12					Jall. 1	/ 5 I	754	01110		
	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside Cit	ty Limits
Be Completed by Funeral Director	MD Baltimore Landsdow							· · · · -			1 ☐ Yes 2 ☐ No XX			
<u>z</u>	10e. Street and Num	nber				10f. Zip C	ode			10g. Cit	izen of V	Vhat Cour	ntry?	
	4166 Hol	lins F	erry Rd.			21:	227					USA		
Jer	11. Marital Status			dent Ever in L		Nas Deceder	nt of Hispanic	Origin? (S	pecify Yes or N	0-			an Indian,	
ᆵ	1 Never Marrie	ed 2 🔯 Marr	Armed Fo. ied 1 ☐ Yes		1	f Yes, specify			o Rican, etc.)		Blac	k, White,	etc.	
þ	3 Widowed	4 Divorced	If Yes, Giv Year or Da	е		I ☐ Yes 🛣	No Spec	city: wh	ite		Specify	: Wl	hite	
ed		15. Decedent			16a Decer	ient's Usual (Occupation			16b K	ind of Bu	usiness/In	dustry	
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Be	17. Father's Name (,						ne (First, Middle	e, Maiden	Sumam	16)		
ဝ	Joseph V	. Culo	tta					Anna :	Laria					
	19a. Informant's Na Mary Culo								ral Route Numi					
	20a. Method of Disp	osition		206.	Place of Dispo	sition (Name	of		Date	20c. Le	ocation -	City or To	own State	
			3 ☐Removal from	State	cemetery, crer			T2 - 1	7 06					
	4 Donation			Lou	don Pai					A	_	re C:		
	21. Signature of Fur	neral Service	Liomsee						udon Pa				ome	
	M	\mathcal{K}	Sola	nax	36	520 Wi.	Lkens	Ave.	Baltimo	re,	MD 2	1229		
	23a. Part 1. Enter th	e disease, or	complications that c	aused the dea	th. Do not ent	er the mode of	of dying, such	as cardiac	or respiratory	arrest,			Approximate Interval Bety	9
	Immediate Cause (I	23a. Part 1 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death Due to (for as a consequence of):												
	resulting in death)	7	a. Coro	911164	11043	T	grun	ru Ji		, 6	140	70		
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=	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	rlying	2 200 10 (or as a conse	querice or).									
an/Medical Examiner	that initiated events resulting in death) L		C											
ω —	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Due to (or as a conse	quence or):									
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⋛	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out			Terr					23d. Dat	te of delive	ЭΓY	
	in the past 12 i			irth 2 🗌 Fet ant at time of]Ectopic preg] Other (spec					Mo	nth	Day Y	'ear
Completed by Physic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	3.40	9□ Unkno			,								
ġ.	Part II. Other signifi	cant condition	ons contributing to de	eath but not re	sulting in the u	nderlying cau	se given in P	art I.	23e. Did	tobacco	use canti	ribute to th	ne cause of de	eath?
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	25. Was case referr	ed to medical					26 D	loop of Doo	th Check only	2 No	'	163	2 140	
o Be	examiner?		Honeitels		TED/O		Othor			11.0				
F	27. Manner of Death		28a. Date		PVOutpatien 28b. Time of		4	INUTSING H	ome 5 Res				y)	
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3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								(Street ar	nd Numb	er or Rura	i Route Numi	ber,		
Ce									., .,		,			
- a	29a. Certifier	1 Certifyin	g Physician: To the	best of my kn	owledge, death	occurred at	the time, date	and place	, and due to the	cause(s	and ma	inner as s	tated.	
듗	(Check only one)	ZX Medical	Examiner: On the ba	asis of exami <i>n</i> per stated.	ation and/or in-	estigation, in	my opinion,	death occu	rred at the time	, date and	d place, a	and due to	the cause(s))
M	29b. Signature and	title of gertifie	r			29c. l	icense numb	oer		29d. Da	te signed	d (Month.	Day, Year)	
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	,	un 1	ex 7	1		and the second	OCI	Æ.		Febr	uary	y 8,	2006	
	30. Name and addre	ess of person	who completed caus	e of death (Ite	m 23a) (Type,	Print)								
		4CC												

State Registrar 31. Date filed (Month, Day, Year)

FEB 1 7 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 7 PState of Mar 81224 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2006 9:35a Valen Lloyd Cameron 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON
If Under 1 Year | If Under 24 Hrs. <u>Gilchrest Hospice</u> Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1⊠M 2□F Director Yrs. 02-17-1935 265-74-0771 70 Jamaica Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Columbia Directo Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Black Rock _Ct. 21046 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes TNo If Yes, Give Year or Dates: 1 Never Married 20 Married Specify African-21215-0036 2 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Tailor Saks Fifth Avenue 12th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mentai H is marked Reginald Cameron Marie Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Depertment of Health at
Important: If Item 27 is
eny injury or other treu 7101 Black Rock Ct., Ella Cameron/Wife Columbia, MD 21046 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Mem. Park 2/20/06 Clarksville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Wylie F/H PA of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23 Part . Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Drostate ears **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown sate has been signed page 2 should be der Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 XNo Certification: To ospice 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural efter death. 1 Tyes 2 No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a. Callillet Medical (Check only one) To the 29b. Signature and Jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 205200 Cen February 16, 2006 Thomas mpleted cause death (Item 23a) (Type, Print) N. Charles St. Balto. md 6701 GBMC

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) Physician 6:24 pM Richard A. Chizmadia /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 13ALTIMORE
If Under 1 Year If Under 24 Hrs. 1 SAINI AGNES HOSDITAL ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 12M 2□ F Yrs 69 9/11/1936 150-26-2913 New Jersey Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State worle r than "natural", or Items 23a or 28a-f ehov tre Medical Exemple proset be notified at 1 Yes 2 No MD Baltimore Catonsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 231 Glenmore Ave. 21228 U.S.A. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any ling yor other traumatic event gote. 17. Father's Name (First, Middle, Last) Julius Chizmadia Anna Mihalko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Chizmadia - Wife 231 Glenmore Ave. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 2/17/2006 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1830 Edmondson Ave. Catonsville, MD 21228 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician UNKNOUN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown HRART Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2110 2□ No 1 TYes within 24 hours after death. **To the Funeral Director:** After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 To the Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUMY 11, 2006 D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSPITME MARLES LUETIS 57 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

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П	Physici	an	1. Decedent's Name (First, Middle, Last) Johnie Lee Danron			2. Date of Deat Month Februar	Day Year	3. Time of Death 2:15 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	, or Location of De		4c. County of Dea	
	Examili	er	1302 Burleigh Road		herville		Baltimore	
	Funeral		5, Social Security Number 6, Sex 7. Age (In yrs. last birthda	y) If Under 1 Yea Months Days		n. (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		402-24-3902			Feb.06,	1924 Jenl	kińs,Ky.
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		****		10d. Inside City Limits
	Mary	tor	Maryland Baltimore County Luther	ville				1 ☐ Yes 2 → No
	th the	Directo	10e. Street and Number	10f. Zip Code)	10	0g. Citizen of What Co	ountry?
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	er de:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of If Yes, specify Cu 	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
336	be filed within 72 hours after death with the Maryland all Hygiene. It Hygiene. Other than "natural", or itema 23a or 28a-f show other. I'm Madical Examination must be notified at	by	1 Never Married 2 Married 1 Yes 2 No W. W. II 1 Yes, Give 1 Yes, Give 1 Year or Dates:	1□Yes 2ÅN	o Specify:		Specify: [White
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and	bed all all all all all all all all all al	Be c	Thomas Blakely			Melviny Co		
Maryland 21215-0036	2 should be and Mental is marked c	To		iling Address (Stree			City or Town, State, .	Zip Code)
	カモトサ		Mella L. Stewart (Daughter) 12 H	Edgemoor !	Ro a d Tir	monium, Ma	ryland 21	1093
ore	of of		Burial 2 Cromation 3 Demoval from State Cemetery, C	position (Name of rematory or other pl			20c. Location - City or	
Baltimore,	. Pages tment of l tant: if it		`4 □Donation 5 □Other (Specify) Dulaney	Valley M			Timonium,	-
Ra	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Java A.	eaceful 2325 York	AIternat: Road T	ives Funer inonium, l	al&Cremat laryland	ion Ctr.,P.A. 21093
	death certificate be executed e attending physician and d for use as the burial-transit	edical Examiner	23a. Part. Enfer the disease, or complications that caused the death. Do not a sheek, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			Diseaso		Approximate Interval Between Onset and Death 1.5 Years
O. Box	that the death certificated by the attending placed for use as to	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. II yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	ncy		23d. Date ol de Month	,	
rds, P	96	by P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【GUnknown			
Hecords,	e taw has b	ompieted				24a. Was ar autops perform	ned? death?	utopsy findings available completion of cause of
VII	iclan: Th certificate rector, pag	e C	25. Was case referred to medical		26. Place of D	1 ☐ Yes 2 eath (Check only one		ZU NO
O	hysician: his certific I director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	tent 3□ DOA O	other: 4 ☐ Nursing	Home 5X Reside	nce 6 Other (Spe	cify)
<u>_</u>	ding Phys h. After this funeral dir	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Injury) 28b. Time	/ W	ork?	28d. Describe ho	w injury occurred	
<u>s</u>	ttendid death. ctor: Ay y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be		□Yes 2□No	201 Leasting (Ct	root and Number or D	una i Consta Alumbra
DIVISION	i or Attendater death Director:	ertificati	determined 28e. Place of Injury - Athome, farm, building, etc. (Specify)	street, ractory, onice	8	City or Town	reet and Number or Ri , State)	arai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after deals, safe deals To the Funeral Director: After this certific completely filled in by the funeral director,	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	s stated. to the cause(s)
	Fo the within 2 Fo the complet	Me	29b. Signature and title of certifier	29c. Licer	nse number	25	9d. Date signed (Mont	h, Day, Year)
	11		Things MD Deputy	DIS	8667	F	Ebruary 1.	5,2006
1	17	-	30. Name and address of person who completed cause of death (Item 23a) (Typ. Philip Militello, MD 6 Irimble	e, Print) H; 11 CT.	Luthenu	ille Mar	. /	1093
	Sta Registr		31. Date filed (Month, Day, Year) 7 2006 32. Projector's Signature	grille)			/	

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Amend Items 10e, 19a, b per SA/G853, 03/02/06dhb and Mental Hygienes are selected and Mental Hygienes are selected.

	Amend Item #9	•	•	if of Health and the off Death		Reg. No.	04638	
Physician /Medical	1. Decedent's Nama (First, Middle, Las	Dau	gherty		2. Date of Dea Month	Day Year	, 12:55pr	
Examiner Funeral Director	313-32-96/2		. last birthday) If Und Yrs. Months	Towson		Baltim		
Marylend f ahow led at	Usual Residence of Decedent 10a. State 10b. County MD Baltimor		ity, Town or Location Perry Ha	111			10d. Inside City Limits 1 ☐ Yes 2√2 No	
offer death with the Maryler ritems 23s or 28e-1 shown ricer must be notified at Funeral Director	10e. Street and Number 9209 Snyder Lane			p Code 21128		10g. Citizen of What 0	Country?	
5-UUZU 72 hours effer death with the Maryland natural, or items 23a or 28e-f show lical Examiner must be notitled at	11. Manital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 13 Yes 2 No If Yes, Give Year or Dates: 155	If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: W		
led within 72 hours of ygiene. Then 'natural', or the Medical Examit, it a Medical Examit.	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo use retired)	orking	16b. Kind of Busines		
Mall yidallu A td 2 should be filed the and Mentel Hygis 77 ta marked other traumatic event, II To Be Cc	17. Father's Name (First, Middle, Last) Hugh DeGoyler Da	ugherty	10COMOT1		me (First, Middle,	<u>railroad</u> <i>Maiden Suma</i> m <i>e)</i> Wavmever		
ges 1 end 2 st t of Health end If item 27 is n or other traun	19a Informant's Name Relationship (7 Laureen Daughert 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Spouse 20b. Removal from State	185209 Stdre 19209 Stdre 19202 Stdre Place of Disposition (N cemetery, crematory or	s (Street and Number or R der Lane er Lane Perr	ural Route Numbe	or, City or Town, State		
permit. Pe Depertmen important: any injury phoge.	21. Signature of Funeral Service Licens	1.1	r State	nd Address of Facility Anatomy Boar		Baltimore	e Street	
Physician /Medical Examiner	23a. Part 1. Enter the disease or comp shock, or heart tailure. List only/o Immediate Cause (Final disease or condition resulting in death)	a. pros	th. Do not enter the mo	de of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death	
certificate be executed ding physicien end se es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of					
v requires that the death certifications are some should be detected for use estered by Physician/Me	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.			ta to the cause of death?	
The law requires that the death centrate has been signed by the ettending page 2 should be deteched for use.					24a. Was perfor	an a <i>u</i> topsy 24t med?	b. Were autopsy findings available prior to completion of cause of death?	
ician: The certificate It irector, page	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2		Othor	ath (Check only o	ne)	1□Yes 2□No	
To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
spital or At nours efter or neral Direct filled in by	4 Homicide determined 29a. Certifier 1 Certifying Phy							
To the Hospit within 24 hour To the Funers completely fill.	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examin and manner stated.	ation and/or investigation	n, in my opinion, death occ	urred at the time,	date and place, and d	ue to the cause(s)	
•	30. Name and address of person who co	ompleted cause of death (Ite	om 23a) (Type, Print)	031865 821 N.	Gataria	2/7/	6 ast md	
State Registrar	31. Date tiled (Month, Day, Year)	32 Registrar's Sign	nature Local	021 /	man s	13	2/20/	

MICHAEL A. DOW 06 - 01132Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, PII, 27 pen/e,2853.3/2//00 II RKD TI, 2/ perMe, 9853,3/2//06 IT State of Maryland / Department of Health and Mental Hygiene 🛛 🗍 🔓 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** FEBRUARY 13. 2006 12:35P. Micahael Alan Dow, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HARFORD 1633 DENISE DRIVE FOREST HILL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 216-78-8348 48 9, 1957 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at 1 XYes 2 □ No Directo Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 303 Princeton Lane 21014 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify: White 3 ☐ Widowed 4 Z Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. Salesman Automobile 7 is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be finent of Health and Mental Cyril Joseph Ruth Vivian Costa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Vivian Dow Mother 303 Princeton Lane, Bel Air, Maryland 21014 f Health Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of important: if it eny injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Top Services Corp 02/16/06 Towson, Maryland 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signatuje of unera 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Fatty liver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9□ Unknown signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Chronic alcoholism 4 Unknown 1 Tes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an has autopsy this certificate he al director, page performed' Yes 2 No Attending Physicien: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death.

1 Director: / 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0

To the Hospital within 24 hours a To the Funaral Completely filled Hospital pellil

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number O.C.M.E.

FEBRUARY 14, 2006

mpleted cause death (Item 23a) (Type, Print) 30. Name and address of person

29b. Signature and title of certifier

Date filed (Month

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111 PENN STREET BALTIMORE, MARYLAND 21201

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1 : C7 PM **Physician** February NINA DAVIS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A Hospital of Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1□M 2√2F SOUTH CAROLINA 96 Yrs. 260-09-3514 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 show other traumetic event, the Medical Evantrar must be political at 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 701 N. ARLINGTON AVE. 21217 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be tiled within 72 hours after a sand Mental Hygiene.

Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -6-HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD HEARST CARRIE PRESSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUANITA MURDEN-RUSSELL (NIECE) 4014 FERNHILL AVE. BALTIMORE, MARYLAND 21215 of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if ites
any injury or ott 1 Burial 2 Cremation 3 Removal from State KING MEMORIAL PARK 2-17-2006 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation man Service Licensed ONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial 3 days **Physician** Intaction disease or condition resulting in death) /Medical Due to (or as a consequence of) xaminer days Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physicien and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter tor u Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 10 10 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ 170 congestive heart failure has this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ij 28a. Date of Injury (Month, Day Year) Atter th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending To the note after death.

Within 24 hours after death.

To the Funerel Director: Att 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 11, 2006 RES - 000 DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn K. Wang DO Sinai Hospital of Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

			1 - For State Registrar		State of	Marylan	,	artmen tificate			and M		Reg. No	11116	04641	
	Physici	an	Decedent's Name (F									Date of De Month	Da	y Year	3. Time of Death	
	/Medic	_	M. Gay		Eustace							Februai		2006	8:30 AM	1_
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Baltimore,	permit. Pages Department of I Important: If its any injury or of		4 ☐ Docation 5 (21. Signature of Funer	-	III.	110	•	2. Name an				11,00	OLL	awa, Ca	mada	_
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Division	er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	f Injury - At ho	ome, farm, st	reet, factory	, office			28f. Location (City or To			ural Route Number,	
	rs afte	Cer														
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	edical	(Check only 2[Certifying Phys Medical Examir	ner: On the bas	is of examina	wledge deat tion and/or in	vestigation	at the till	oinion, dea	d place :	and oue to the ed at the time.	date an	d place, and due	e to the cause(s)	
	the H hin 24 the F	Medi	one)		and manne	r stated.										
	1 Miles	-	29b. Signature and title			t-> M =				number				ite signed (Moni		
•	7		1000000	とする、			-1-		2374	3			rebr	uary 8,	∠006	
	10		30. Name and address Martin W			of death (Item Green			eenh	elt.	MD 2	20770				
) 	ate.	31. Date filed (Month,	-		gistrar's Signa	-	., GI	CCIID	,						
	Sta Registi			1 7 2006	197	w At	4900	N. C.								

		-	For State Registrer		State of Ma	aryland		artment <i>tificate</i>			ind M	ental F	lygien Reg. N	400	6	04642	
			Decedent's Name	(First, Middle, La	st)				0, 2		Į	2. Date of	Death			3. Time of Death	
	Physicia /Medic		Joyce		Норе		Emery					Month Februa		ay 200	Year 6	9:50p	A
	Examin				e street and number)			4b. City, T	own, or L	ocation o	f Death		-	c. County o		21200	
			Joseph R						timo		Od Hen			N/A			
	Funeral Director		5. Social Security Nu	1	□M 2RF	e (In yrs. las	t birthday) Yrs.	If Under	Days	If Under a	Min.		Day, Yea			lace (State or Foreig try)	In
			201-30-52 Usual Residence of			8						Jan.	29, 1	938 P	enns	ylvania	
	nylanc how		10a. State	10b. County		_	Town or Lo								1	0d. Inside City Limits	
	a Ma	cto	Maryland	N/A		Bal	timor	е								1-Yes 2 No	3
	vith th	Dire	10e. Street and Num					10f. Zip	Code				10g. C	Citizen of WI	hat Cour	try?	
	death with the Maryland ms 23a or 28a-f ehow rimust be notified at	erai	773 West	Cross S	treet 12. Was Decedent I	Ever in II S	12.1		230	nania Orie	nin? (Sno	oifu Vac ar	No-	USA 14. Race	- Amoric	an Indian	
^	r Item	Funeral Directo	1 Never Marrie	ed 2 Married	Armed Forces?		1	Was Decede f Yes, speci		, Mexican	, Puerto	Rican, etc.)	NO		, White,		
3	filed within 72 hours after Hygiene. ither then "natural", or Ite ont, it e Medical Exantina	þ	3 [™] Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2	₩ No	Specify:				Specify:	Whi	te	
ה ה	72 ho	Completed		15. Decedent's E fy only highest gra			16a. Deced	dent's Usual	Occupat	ion irina most	t of worki	na	16b.	Kind of Bus	iness/In	lustry	
7	vithin hen	mpi	Elementary/Secon		College (1-4or 5	+)		kind of work DO NDT use				3					
N T	Hygie Hygie ther t	e Co	12 17. Father's Name (/	First Middle Last)		Hom	emake		18 Mothe	r's Name	(First Mid	dle Maide	Own en Sumame			_
<u> </u>	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Ma	6	William		Arthur		Rar	tell			nett		J.O., 11121G	511 54714.176	,	Rice	
2	should nd Men marke amatic	ဥ		me/Relationship (Type, Print)Per.R	ep.			(Street ar				mber, City	y or Town, S			
Ĕ	alth a 27 io		William T	. Katzen	berger, Sr		773	West	Cross	s Sti	ceet,	Balt	imor	e, MD	212	30	
a)	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygene. If item 27 is marked other then "natural; or items 23a or 28a-1 show or other treumatic event, it a Medical Exam as must be notified at		20a. Method of Disp		1 0 01 01	20b. Plac	e of Dispo	sition (Nam	e of her place)	D	ate	20c.	Location - C	City or To	wn, State	
altimo	Page ment: if ant: if ury or			□ Other (Special]Removal from State (y)	i		rk Cei		1	2/8/0)6	Ba1	timor	e, M	aryland	
	permit. Pages 1 and 2 Depertment of Health a Important: if item 27 is any injury or other tre		21. Signature of Fur	neral Service Lice	nsee		10.7	. Name and					Park	Fune	ral	Home	
_	40 E # 9	do o	11				-							e, MD	212		
					plications that caused one cause on each lin	the death.	Do not ent	er the mode	of dying,	, such as	cardiac c	r respirator	y arrest,			Approximate Interval Between Onset and Death	
)	Physician / /Medical		Immediate Cause (I disease or condition resulting in death)	rinal	a. Car	einoma	a (pe	nemice	اي م	e) of	had	+ nu	k			Honorths	
	Examiner		,	- (Due to (or as	a consequer	ncerof):			v							
		er	Sequentially list con if any, leading to imi- cause. Enter Under Cause (Disease or i	nditions, mediate	b. Due to (or as	a consequer	nce oi):										
	uted d ansit	Examiner	Cause (Disease or i that initiated events	rlying njury	6												
Š	en ar urial-tı	Exa	resulting in death) L	ast	Due to (or as	a consequer	nce of):										
00/00	ificate be executed g physicien and ss the burial-transit	edical			d										-		
		/Med	IF FEMALE:		220 litura cutaama	a.											
X00	es that the death certifigened by the attanding be detached for use e	Physician/M	23b. Was decedent in the past 12 a	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3[Ectopic pre						23d. Date Mon		ory Day Year	
j.	the de y the ched	iysic	1 ☐ Yes 2 € 9 ☐ Unknown	No	9 Unknown	time or dear	ui 3L	J Other (Spe	C119/				-				
7	that the	by Pr	Part II. Other signifi	cant conditions	contributing to death b	ut not resulti	ing in the u	nderlying ca	use giver	n in Part I.		23e. D	id tobacc	o use contri	bute to the	ne cause of death?	
cords	w requires been sign should be		mites	stores to	Erain							1	☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknow	'n
000	iaw requires as been sign 2 should be	Completed	His	20.60	mitastas	سا						24a. W		24b. W	/ere auto	psy findings availab	le
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<u> </u>	clan: ertifica	Be (25. Was case referr	ed to medical							of Death	Check on	-				-
50	Physical this call dire	ပ္	1 ☐ Yes 2 ☐			ent 2 EF			_	4 🗀 190				6 XOthe		1) Haspice	ر
	Jing F	ertification;	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	y Year)	8b. Time o Injury	M 28	Bc. Injury Work	at ? es 2 □		28d. Descri	be how in	njury occurre	∌d		
DIVISION	Attending ir death. ector: After by the fune	licat	2 Accident 3 Suicide	investigation	OB Diese of lei	urv - At hom	e. farm. str			63 Z	-	28f. Locatio	n (Street	and Numbe	r or Aura	il Route Number,	_
<u> </u>	after Dire	erti	4 Homicide	determined	building, et	c. (Specify)	0, 14111, 31	oot, radory,	Onice				Town, St			r route rearribor,	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerei Director: After this certific completaly illied in by the funeral director,	O	29a. Certifier	Certifying P	hysician: To the best	of my knowle	edge, deat	h occurred a	at the time	e, date an	d place,	and due to	the cause	(s) and mar	ner as s	tated.	
	the Hu in 24 the Fu pletal	edicai	(Chack only one)	∠ medicāl Exa	miner: On the basis of and manner sta	f examinatio	n and/or in	vestigation,	in my opi	inion, dea	th occurr	ed at the tir	ne, date a	and place, a	nd due to	the cause(s)	
	With To t	Σ	29b. Signature and					29c.	License	number			29d. l	Date signed	(Month,	Day, Year)	
•	/		Swil	um Ben	edict ms				00 8	583			2/	5 100			
	5		30. Name and addre	ess of person who	completed sauce of d	loath (Itam 3	3a) (Type,	Print)	0 4		4	4 9 1-	_				
	Sta	to.	G. William 31. Date filed (Mont		32. Pegistr	ar's Signatur	VALE re	57.	Bult	7007	E M	ノノスノ	+				
Ē	Registi			EP 1 7 2			1	seak!									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** County of Death ebruari 2030 Lynn Emerson /Medical 4c. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocake Modical Cente Harford Bel 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 X F Mary Director Usual Residence of Decedent 10c. City, Town or Location Od. Inside City Limits 10a State 10h County 28a-f ehow traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Harford Bel Air Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò USA 21014 7 Edgehill Court 238 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be tiled within 72 hours aft Department of Health and Mental Hygiens. Important: If tiem 27 is marked other than "natural", or is any injury or other traumatic event. Its experience once. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michele Faraglia Maureen Emerson Richard Kevin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Edgehill Court, Bel Air, Maryland Kevin Emerson/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens 2-18-2006 Bel Air, Mardland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Hohydramnios **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner gene Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner losaicism with Trisomy 14 thromosomal Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. À 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Manner of Death Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of codifie D033079

State Registrar

30 Name and add

Bellantoni, M.D. 308 N. Union Ave. Howrede Grace, mD 21078 32. Registrar's Signature 31. Date filed (Month, Day, Year) 7 2006

person who completed cause of death (Item 23a) (Type, Print)

Fune

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be datached for use as the burial-transit Division of Vital Records, P.O. Box 68760, ✓

		For State Registrar	Otate of Mary		tificate of			g. No.	6 04644			
sicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Feb. 1	5 ^{Day} 2006	3. Time of Death			
edic	al	Rose Ann For			Ab Ciby Tourn o	r Location of Death		5 2006 4c. County of				
min	er	Gilchrist Nur		er	Tov	son		Baltim				
ral tor		212-42-9022	x 7. Age (In)	/rs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 6,	Year) 1945	Birthplace (State or Foreign Country) PA			
	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
	to											
	Funeral Director	10e. Street and Number 369 Nicholson	at Country?									
	ner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13. V	Was Decedent of H		American Indian, White, etc.					
	þ	1 Never Married 2 Married 3 Xidowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		I□Yes 2⊠ No	Specify:		Specify: White				
	ete	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	lent's Usual Occup kind of work done	nation during most of work d)	king 1	6b. Kind of Busin	ness/Industry			
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2VIS		retary	2)		Law Fi	rm			
	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)				
	70	Albert John Li	povsky			Edna Ce	ntenial					
		19a. Informant's Name/Relationship (Ty			_	and Number or Rui						
		Edna Lipovsky /mother 8206 Peach Orchard Road Baltimore MD 20a. Method of Disposition Commetery, Crematory of other place) 1 Burial ACCremation 3 Removal from State BayviewCrematory 2/20/2006 Baltimore MD										
ė		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License							omeofEssex			
once		R. Teling (onnell	u		ce Ave.						
		23a. Part1. Enter the disease, or compleshock, or heart failure. Liet only or	ications that caused the dine cause on each line.	eath Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between			
an		Immediate Cause (Final disease or condition resulting in death)	. End	- Stag	re rev	in I fa	ilvre		Onset and Death			
al er		resulting in dealin)	Due to (or as a con	sequence of):	4.0	llitus			Dean			
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	Sequence of):	s me	cerus			genes			
	Examiner	triat initiated events	c									
	EX	resulting in death) Last	Due to (or as a con	sequence of):								
	Medical		1									
		IF FEMALE: 23b. Was decedent pregnant 2	23c. If yes, outcome of pre					23d. Date of	of delivery			
	Be Completed by Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time 9 Unknown		Ectopic pregnancy Other (specify)	<i>'</i>		Month				
	oy P	Part II. Other significant conditions con	-				23e. Did toba	acco use contribu	ute to the cause of death?			
	ted	Hyper tens	on, 056	Noch	ne A.V	WAY	1 Tes	2 M No 31	Probably 4 Unknown			
	nple	disease					24a. Was an autopsy	24b. We prio	re autopsy findings available or to completion of cause of oth?			
	S						perform 1 Yes 2	ed? dea X No 1 □	ith? Yes 2 No			
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2♥Z No	Hospital:	2 ER/Outpatien	t 3 DOA Oth	or	th (Check only one		(C			
	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year				28d. Describe how		77/1			
	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 da.	, injury		Yes 2 □No						
	Medical Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	dicai	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and mann te and place, and	er as stated. If due to the cause(s)			
	Me	29b. Signature and title of certifier	1 50		29c. Licens		29	d. Date signed (/	Month, Day, Year)			
		Ill Anthon	y Mily.	ans	025	5205	F	e brum	715,2006			
5		30. Name and address of person who of	0	Item 23a) (Type,	Print) howles.	St. Bol	to med	2120	۶			
Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Si	ignature	ante							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04645 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Patrick 3:00 AM February Frederick 12,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. Puth <u>3227</u> Battimore 117 Avenue 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1**X**M 2□F 48 Yrs. Director 217-78-1243 February 8,1958 Maryland Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Itams 23a or 28a-f show traumatic event, tre Modical Exertinar must be notified at 1 Yes 2 No Director Baltimore WD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3227 Avenue 21234 HH. SA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after cand Mental Hygiene.
Is marked other then "natural", or Itar 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Frederick. William tathicia Lease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny Injury or other traum <u>page.</u> 3227 Putty Brathleen Theresa Frederik-Wife Avenue Baltimuse MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Evans Chapel or Memories 4 Denation S Other (Specify) Forest Hill, Maryland 8800 Harford Boad, Parkville Maryland 21235 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER RENAL CELL **Physician** METASTATIC year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/S-No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital:

Division of Vital

death. ŏ the

within 24 hours after deat To the Funeral Director: State

this

After

the

filled in by

Certification:

29b. Signature and title of certifier Denous 29c. License number

1 ☐ Yes 2 ☐ No

Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Belgir

MD

28d. Describe how injury occurred

D40480 7602

rebruary 13, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO

28a. Date of Injury (Month, Day Year)

tenno, MD

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

7 2006

5 Pending

investigation

determined

6 Could not be

Registrar

Amend item#28a-e,31/per MD 852,2/17/00 11

			1 - State Registrar		of Marylar			f Health a	nd Mental H	Reg. No	O O O	04646
	Physici /Medic		Decedent's Name (First, Middle,		za1i	Sanche	ez Fern	andez	2. Date of 0 Month Febr	Da	y Year 11,2006	3. Time of Death 10:30 P M
	Examir		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Tov	n, or Location of	Death	40	. County of Death	1
1.0	Funeral		9878 Bird Rive 5. Social Security Number	. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		4 Hrs. 8 Date of F	Birth Day, Year)		imore Co. aplace (State or Foreign untry)
	Director		219-71-4612	1□ M 2□ x F		Yrs.	Months Di	B Hours	March	14,2	2005 M	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Maryll f eho	ō	Maryland Ba	ltimore		,,		Middle	River			1 ☐ Yes 🏋 No
	r 28a-	Directo	10e. Street and Number	1011101			10f. Zip Co	de		10g. Ci	tizen of What Co	untry?
	h with		9878 Bird Riv	er Road				2122	20	Un:	it e d Sta	tes
စ္	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or iteme 23a or 28a-f show event, the Medical Exercitar must be notified at	Funeral	11. Marital Status XX Never Married 2 ☐ Marrie	Armed F	2 ⊠ No		Was Decedent If Yes, specify	No Specific	in? (Specify Yes or I Puerto Rican, etc.)	-	14. Race - Amer Black, White Specify:	
5-003	urel',	d by	3 Widowed 4 Divorced	Year or	Dates:			É	El Salvado		His	panic
iÒ	"neti	Completed	15. Decedent's (Specify only highest)	16a. Dece	dent's Usual O kind of work d	ccupation one during most (atired)	of working	16b. K	(ind of Business/	ndustry
2121	within then then	d Ho	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	Dependa				N/A	
D D	Hygid other	Be C	N/A 17. Father's Name (First, Middle, La	est)					's Name (First, Midd	le, Maider	Sumame)	
aryland	should be nd Mental marked o	To B	Luis Sanche	Z				Vic	torina Fe	rnand	dez	
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationshi Victorina Fernan		ther)	19b. Mailir 987	ng Address <i>(St</i> '8 Bi r d	reet and Number River R	or Rural Route Num oad Midd	le R	or Town, State, Z iver, MD	^(ip Code) 21220
re,	s 1 a		20a. Method of Disposition		20b.	Place of Dispo			Date	20c. L	ocation - City or	Town, State
timore,	Page nent c nnt: M ury or	- 11	14 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		n State				2/18/2006	iM	lddle Ri	ver, MD
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked ent injury or other traumatic e 200ce.		21. Signature of Funeral Service Li	censee MC	issey	A D	2. Name and A	ddress of Facility		f Dur	ndalk, I	nc. 1222
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that	caused the dea							Approximate Interval Between
1 - 1	Physician		Immediate Cause (Final disease or condition	pr	Run	noni	a					Onset and Death
<i>?</i> `.	/Medical		resulting in death)	Due to	(or as a conse	quence of):	1 /	•				48 hours
5	Examiner		Saquentially list conditions, if any, leading to immediate	b COV	nples	C 1 6	defic	dying, such as c	4			11 months
V	ted nsit	Examiner	Cause (Disease or injury	D09 10	or as a conse	quence oi).		Q				
<u>.</u>	ificate be executed g physicien end as the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):						
68760,	sicie ysicie	edical		d.								
	rtifica ng ph as th	Medi	IF FEMALE:									
Вох	The law requires that the death certif tie has been signed by the ettending rage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		utcome of pregn birth 2 ☐ Fet		Ectopic pregn	ancy			23d. Date of deli	very Day Year
O.	the elf	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of nown	death 5	Other (specif	y)		-	TO STATE	ou, rou
о. О.	that the		Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying caus	e given in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
Records,	uires sign	d by	hypotonie				, ,		1[Yes 2	No 3 Pr	obably 4 Unknown
Ö	w require been sign	Completed	dyscoorder	0/0 5	1001	Ser 1			24a. W	as an	24b. Were au	topsy findings available
æ	he lay	E C	2,3000,00	رت) المع	00000				au pe	topsy rformed?	prior to death?	completion of cause of
ta	isclan: Th certificate rector, pag	Be C	25. Was case referred to medical					26, Place	1 ☐ Yes of Death (Check on!		1 □ Yes	2 □ No
Division of Vital	Attending Physician: or death. ector: After this certifice by the funeral director; p	To B	examiner? 1 Tyes 2 No	Hospital: 1	Inpatient 2] ER/Outpatier	nt 3 DOA	044	sing Home 5		6 ☐Other (Spec	cify)
0	ng Pt fter tt neral	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mo	of Injury onth, Day Year)	28b. Time o	f 28c.	Injury al Work?	28d. Describ	e how infu	iry occurred	
<u>sio</u>	tendi leath. tor: A the fu	cati	2 Accident investigation in Suicide 6 Could no	the J	106	le P	М	1 ☐ Yes -2/1 N		0/0	-	
\leq	or At ifter d Direct in by	ertification:	4 Homicide determin	ed 288. Plac	ce of Injury - At t ding, etc. (Spec	nome, farm, st ify)	reet, factory, of	fice		(Street a. Town, Stat		iral Route Number,
	ppltei	O	29a. Certifier 12 Certifying	Physician: To the		owledne deat	h occurred at t	ne time, date and	place, and due to the	na causals	and manner as	stated
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical E	caminer: On the	basis of examin inner stated.	ation and/or in	vestigation, in	my opinion, death	occurred at the tim	e, date an	id place, and due	to the cause(s)
	vithin To th comp	Me	29b. Signature and title of certifier					cense number			ate signed (Monti	n, Day, Year)
			▶ CBlourdell	MD			BM	46891	064	2	113/06	
	2	69	30. Name and address of person w	ho completed ca	A		Print)	2 1	6-15	2	nd	e MD2/20/
	-		Carol Blaisde		14	pland	13 1	W, Lo	nuard st	- 124	ente mis	< 11 0x/20/
	Sta		31. Date filed (Month, Day, Year)	2006 32.	degistrar's Sign	acure	seeke)					

		For State Registrar		epartment of Heal		giene 0 0 6	04648
Physici /Medio		1. Decedent's Name (First, Middle, Last) Mary Fo	4		2. Date of De Month Febilu		3. Time of Death
Examir		4a. Facility Name (If not institution, give street a	General Hosp	4b. City, Town, or Loca		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 2	7. Age (In yrs. last birt	hday) If Under 1 Year If U Months Days Ho	urs Min. 8. Date of Bir (Month, Park) Aug • 10	9. Birth 1924	nplace (State or Foreign untry) Maryland
faryland show	'n	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. City, Towr	or Location		:	10d. Inside City Limits 1 ☐ Yes 2 No
th the N or 28a-f e notifi	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
s 23a (s 23a)	eral [3504 Dairy Valley Tr		21042	in Origin? (Specify Veneral)	USA 14. Race - Ame	ican Indian
DESILITION OF BY INTERVIEUR Z IZ 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expire Actional be notified at once.	þ	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?]Yes 2 2 No es, Give ar or Dates:	13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 X No Spe	c Origin ? (Specify Yes of No xican, Puerto Rican, etc.) ecify:	Black, White	
hin 72 ho 9. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Co		Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/	industry
iled wit Hygiene Her tha		12 17. Father's Name (First, Middle, Last)		Homemaker	Mother's Name (First, Middle	Own Home	
Vicanical vicion of the vicion	To Be	John James Thompse	on	18.	Genevieve		
MICH YIE d 2 should th and Mer th and Mer to 1s marke traumatic	ľ	19a. Informant's Name/Relationship (Type, Pri G. Allen Foy, Jr.		Mailing Address (Street and N)5 Saddle Ridge			
ore, IV		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or	
diffilm Of rmit. Pages spartment of I portant: If Its sylnjury or o		*4 □Donation 5 □Other (Specify) 21. Signature Funeral Service Lensee	Lorra	ine Park Cem.		Baltimore,	
permit. Departn Departn Imports any Inju		1 debece 2	Osse	Funeral Home 1630 Edmonds	of Catonsvil on Avenue, Ca	Te linc believe tonsville, N	4D 21228
Physician		23a. Part 1. Enter the disease or complications shock, or heart failure. st only one cause Immediate Cause (Final disease or condition	s that caused the death. Do not se on each line.	petri sho petri sho semie bo semie bo solo: sett rena solo: soched lu	th as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner			Due to (or as a consequence	iemie bo	wel dise	arl	
uted	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	on:	1 tailue		
cate be executed cate be executed obysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	of):	uer		
oo/ tificate ig physias the	ledical	d	300				
Thecords, P.O. Box 66/700, The law requires that the death certificate be executed at a has been signed by the attending physician and age? should be detached for use as the burial-transit	hysiclan/Me	in the past 12 months?	es, outcome of pregnancy]Live birth 2	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
quires that in signed by	by P	Part II. Other significant conditions contributions of the significant conditions contributed to the significant conditions conditions contributed to the significant conditions conditio	ng to death but not resulting in	4	and in the	tobacco use contribute to	the cause of death?
Hecords, he law requires t has been signe ge 2 should be	ompleted	atual Assillar	lion	1	24a. Was		topsy findings available completion of cause of
on or vital recting Physician: The lav h. h. After this certificate has funeral director, page 2.3	O	25. Was case referred to medical		26.	1 ☐ Yes	2 X No 1 ☐ Yes	2 No
OT VICA Physician: this certific ral director,	To B	examiner? 1 Tyes 2 No Hospita	Inpatient 2 ERVO	tpatient 3 DOA Other: 4	□ Nursing Home 5 □ Res	idence 6 □Other (Spec	cify)
nding F ath. r: After e funera	atlon	27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident investigation		Time of 28c. Injury at Work? M 1 Yes		how injury occurred	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification;	a Could not be	p. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location City or To	(Street and Number or Ruwn, State)	iral Route Number,
e Hospit 24 hours e Funera etely fille	edical C	(Check only 2 Medical Examiner: 0	To the best of my knowledge n the basis of examination an nd manner stated.	, death occurred at the time, dad/or investigation, in my opinion	ite and place, and due to the , death occurred at the time	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the vithin To the compl	Me	29b. Signature and title of certifier	m_	29c. License num		29d. Date signed (Monti	h, Day, Year)
10		30. Name and address of person who complete	ed cause of death (Hem 23a)	(Type, Print)	ne Clark	resnon!	2004
1		Suran Abdo	5005 Sign	al sell la	ne llaur	ulle MD	21029
St Regist	ate rar	FFR 1 7 7006	32. Registrar's Signature	Sporte			

			For Stata Ragistrar	State of Maryland	d / Depa	artment of F	lealth and <mark>l</mark> Death		ene)	06 0464	9
			Decedent's Name (First, Middle, Last)					2. Date of Deat	1	3. Time of Death	
	Physici		NIZA GRIFFIN					Month February	Day	Year 3:00 A	М
1	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death		4c. County		~
	CAMITI	Ç.	UNION MEMORIA			BALTIMO				NA	
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs. Is	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 918	Birthplace (State or Fore Country) NC	ign
			Usuel Residence of Decedent					12.04.	410	INC.	
	how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limi	
	e-f.	Director	MD NA	BALT	MMOR	E				1 @ -Yes 2 □ N	10
	th the	lre	10e. Street and Number			10f. Zip Code		10	og. Citizen of	What Country?	
	23a		6801 LOCHRAVEN	BLVD.		212	39		{	USA	
	eme eme	Funeral	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - American Indian, ick, White, etc.	
36	s afte	by F.	1 Never Married 2 Married	1 ☐ Yes 2 MS.No If Yes, Give		1 ☐ Yes 2 KNo			Specif		
Ş	filed within 72 hours after death with the Maryland Hygiens stan "natural", or iteme 23a or 28e-f show other than "natural", or iteme Than the notilliad at	D D	3 🗷 Widowed 4 Divorced	Year or Dates:	16a Dass	death Havel Octor	ation		ICh Kind of B	BLACK	
<u>.</u>	n 72 n nai	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	160. Kind of B	Business/Industry	
7	withi ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ABORER	-/		HOSPI	TAL	
Ö	Hyg other	BeC	17. Father's Name (First, Middle, Last)	<u> </u>		10000	18. Mother's Nar	ne (First, Middle, A	faiden Sumar	me)	
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28e-f show entry injury or other traumatic event, the Madical Examiner must be notified at once.	To B	WILL DAWSON				NANCY	HOMARD			
7	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Typ	7 '	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town	, State, Zip Code)	
	Heelth a tem 27 le		ELSON DAWSON	(SON)	6802	. UPPER	MILL C	IR. CATO	NSVIW	E MD 21228)
=	of He		20a. Method of Disposition 1	l 00	ace of Dispo emetery, crea	sition (Name of matory or other pla	сө)	Date	20c. Location	- City or Town, State	- 27
altimore,	Pages ment of ant: If it ury or o		4 □ Donation 5 □ Other (Specify)	KIN	IG PA	RK	02. 2	22.06 R	ANDAUS	STOWN, MO	
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service License	f	VQ	2. Name and Addre	SS of Facility	FUNERAL S	SERVICE	<u> </u>	
	40 E E G		Vangha .	<u> </u>	51	51 8AUTO:	NATE PIK	E, BAUO	. MO 2	21229	
		-	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each fine.	. Do not en	ter the mode of dyli	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death	
)	Physician		Immediate Cause (Final disease or condition resulting in death)	Pneumonia						10 days	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					J	
	4	-	Sequentially list conditions, b	. Due to for as a consecu	ience off:						
T	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury								
V	execunation and ial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
8760,	cate be executed physicien and the burial-transIt	dical	L _d								
89	ng ph as th		IF FEMALE:								
õ	th ce tendii or use	an/	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetel		∃Ectopic pregnanc	v			ate of delivery onth Day Year	
Division of Vital Records, P.O. Box	w requires that the death certific been signed by the attending t should be detached for use as	Completed by Physician/M	in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)			M	onth Day Year	
<u>o.</u>	d by	든	Part II. Other significant conditions con	tributing to death but not rose	ulting in the u	andorhijag sauco an	on in Part I	23a Did toh	2000 HEB COD	ntnbute to the cause of death?	
g Q	signe bed	d by	Cormacy anton	disease	itting in the c	inderlying cause gr	verriir zi(i.			3 □ Probably 4 □Unkno	
Š	requ been shoul	etec	OF 1 Colours	,							
ee Be	has ge 2	E G	Atrial fibrillati	,				24a. Was a autops	y ned?	Were autopsy findings availal prior to completion of cause of death?	of
	n: The	င္ပ	Dichetes Mellit 25. Was case referred to medical	NS					2 No	1 ☐ Yes 2 ☐ No	
⋚	sicia : certi irecto	00	examiner?	ospital:	EB/Outpation	nt 3 DOA Ott	her	ath <i>(Check only on</i> Home 5 ☐ Reside		h (C(L)	
ð	y Phy ar this eral d	٠ <u>.</u>	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe ho			
<u>0</u>	ath. r: Afte e fun	atlo	1 Matural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		nk?]Yes 2∐No				
<u> </u>	er der recto by th	1110	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (St City or Town		ber or Rural Route Number,	
Ö	Itel or irs aft ei Dir led in	Certification:									
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examin	ician: To the best of my kno- ter: On the basis of examinal	wledge, deat	th occurred at the ti	me, date and place opinion, death occu	e, and due to the caured at the time, d	ause(s) and mate and place	nanner as stated. , and due to the cause(s)	
	thin 2 the mplei	Med	one) 29b. Signature and title of certifier	and manner stated.	(5	29c. Licen:	se number		9d Date sign	ed (Month, Day, Year)	
	8 4 5 4		WALID BAR	BOUR /	5		138946		_	4 16, zeo6	
7	1		30. Name and address of person who co		232) /7		10 0 TTO		CULHAN	9 10, 2000	
	4		WALID BARBOUR,				D				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		6 - 14					
	Regist	rar	FERT (28	Uh A Sistanza	AL AS	2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrer	State of Mary		artment of ertificate of			iene eg. No.	04650
	Physicia	an	Decedent's Name (First, Middle, Last)		ſ			2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	AIF rieda E		oodno		and anotion of Dooth	February	4c. County of Dea	
	Examin	er	Citizens Dursin	1.1		Havre	or Location of Death		Harfa Harfa	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday	If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		213-01-0041	M 2∏ F	97 Yrs.	Months Days	nouis Min.	November	26,1908 Mar	yland
	and w	Ì	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Maryl	tor	Maryland Baltimor	e	Roseda	ale				1 ☐ Yes 2X No
	th the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23e c	Funeral Director	5026 Brightleaf Co				21237		USA	
	er des Items	nue		12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
336	72 hours after death with the Maryland natural; or Items 23e or 28a-f show Iteal Examinat must be molified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 27 No If Yes, Give Year or Dates:		1□Yes X No	Specify:		Specify: Wh	ite
21215-0036	72 hou	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Dece	edent's Usual Occi	upation e during most of work	kina	16b. Kind of Business	
21	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	rg		
	filed wil Hygien other the		10 years 17. Father's Name (First, Middle, Last)		I I	Housewife		na (First Middle i	Own Hom Maiden Sumame)	<u>e</u>
lano	ld be i ental I ked o ic eve	To Be	Bernard Wolf				Anna Bo		The state of the s	
Maryland	2 should be and Mental is marked of reumatic ev	_	19a. Informant's Name/Relationship (Ty	pe, Print)			et and Number or Ru	rai Route Number	r, City or Town, State,	
	1 and 2 Health a tem 27 is		Jack Goodman	son		_	eaf Court,	_	e, Marylan	
lore	Pages 1 nent of H nnt: If iten iry or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	amoval from State		ematory or other p		uary	20c. Location - City or	
Baltimore,	그 돈 뿐 글		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 			dge Memor	, 10,		Halethorpe	
Ba	Demi Depa Impo any id		Enthony C	. Conne					oundalk,P.A Oundalk,MD.	21222
			23a. Pan1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the ne cause on each line.	death. Of not er	nter the mode of d	ring, such as cardiad	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	۷	very a	tratio	7)			4 WKs
	Examiner		· ·	Due to (or as a co	lain	bralio ulnt	100			8 wxs
	7 =	ner	f any, leading to immediate cause. Enter Underlying	Due to (or as a co						
1	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
,09	ificate be executed g physician and as the buriat-transit				msaquanca or).					
68760,	flicate g phys as the	edical		3						
Вох	death certifii e attending i id for use as	In/M	23b. was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		□Ectopic pregnar	rev.		23d. Date of de	,
O. B		hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
۵.	that the	٥	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying cause o	uven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
of Vital Records,	requires that the een signed by th hould be detache	d by	Deme	nlea		, ,	,	1 □ Y	es 2₽No 3□P	robably 4 Unknown
COI	aw requir as been si 2 should	ompleted						24a. Was a		utopsy findings available
Re	he ha							autops perfor	med? death?	completion of cause of
/ita	ician: T certificat rector, pa	BeC	25. Was case referred to medical examiner?					th (Check only or		
of \	hys this al di	10 10	1 ☐ Yes 2 ☑ Mo	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	ant 3 DOA			ence 6 Other (Spe	ecify)
		tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		W	ork? □Yes 2□No	200. Describe in	ow injury occurred	
Division	il or Attendir after death. Director: A d in by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, s	treet, factory, offic	8		itreet and Number or F	lural Route Number,
ā	Hospitel or Attending 24 hours after death. Funerel Difector: After tely filled in by the fune	Certification;	4 El Homeido	building, etc. (\$	apacity)			City or Tow	n, Sale/	
	To the Hospitel within 24 hours a To the Funerel completely filled	edical		sician: To the best of m ner: On the basis of exa and manner stated	amination and/or i					
	To th withir To th comp	Me	29b. Signature and title of certifies	v MD			nse number	2	29d. Date signed (Mon	*
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	4		30. Name and address of person who co	Milliam M	h (Item 23a) (Type	Revolu	tion St H	ONTED	E Graum	W 21078
2.	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 4				

DHMH 17 Rev 1/2001

Goorman, Alfrieda E,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Earl Dixon Goetz February 17, 2006 7:12 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∏**M 2□ F Director 215-09-8137 93 Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event, the Martical Examinar must be notified at Yes 2□No Directo Maryland | n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: It Item 27 is marked other than "neture!, or Ite eny injury or other traumatic event, the Medical Examinia. 1 Myes 2 □ No If Yes, Give Year or Dates: 1943–46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) shipping clerk retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Goetz Pearl Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Goetz – sister 221 South Pulaski Street, Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/2006 Baltimore, Maryland 4 □Donation 5 □Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. PDC9. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** dement /Medical resulting in death) Due to (or as a consequence of): Examiner docere Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the ettending physicien and thed for use es the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the el 5 Other (specify) ☐Yes 2☐No 9

☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Injury 12 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shope MD 00033150 FEB 1747 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 110 21045 9650 SANTIAGE ROAD ShALLINMALA GUPT A COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician Helen M. Gubernatis reb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HIF Bel Air Nursing and Rehab. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🛱 F 213-03-8126 91 Director 2/4/1915 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits in then "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Completed by Funeral Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 254 S. Monastery Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is marked other then "I r treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 0 Home maker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thent of Health and Mental Hitem 27 is marked out Be Peter Bobelis Constance Vraitis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is 3635 Longridge Court, Abingdon, Maryland 21009 Lawrence Gubernatis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: If any injury or once. Bayview Crematory 1/20/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 090 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 1 ☐ Yes 20 No W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 6 Could not be 3 🗌 Suicide

Subernatis Certification: To or Attending after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Func completely f and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D262 172 6106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR MD 206 HAYS ST SHILPI KHOSLA #102 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Signer ! FEB 1 7 2006 Sell and Registrar

		. FOI	partment of Health and Mertificate of Death	lental Hygie	2006)4653
Physic		Decedent's Name (First, Middle, Last) Josephine Elise	Grove	2. Date of Death Month February	Day 11, 2006	3. Time of Death 4:50 P M
/Medi Exami		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	Co
Funeral Director		Manor Care Ruxton 5. Social Security Number 6. Sex 1 □ M X F 7. Age (In yrs. last birthd 218-01-4649 88	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 18	9. Birthp	lace (State or Foreign htry)
enyland ehow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o			1	0d. Inside City Limits
th the Ma or 28a-f	Director	Maryland Baltimore 10e. Street and Number	101. Zip Code	ville 10g.	Citizen of What Cour	1 ☐ Yes ZANo
ath wi		1739 Wentworth Avenue	21234		nited Stat	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Items 23a or 28a-f show event, the Medical Exertiting could be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
ithin 72 ho	Completed	(Specify only highest grade completed) (G	scedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing	. Kind of Business/In	
fed will her th		7 TEALS	partment Manager		Food Marke	et
d be fi	Be	17. Father's Name (First, Middle, Last) Cyrus A. Bevars		e (First, Middle, Maio M. Meadow		
d 2 should be filed within the and Mental Hygiene. 7 le marked other than traumatic event, the Mental Hygiene.	10	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run	al Route Number, Ci	ty or Town, State, Zip	
and 2: and 2: ealth ar m 27 le		Gloria L. Bromwell (Daughter) 17	39 Wentworth Avenue	Parkvil	le, Maryla	and 21234
Pages 1 nent of H int; If ite		1X Rurial 2 Cremation 3 Removal from State cemetery,	sposition (Name of crematory or other place) ridge Mem. Park 2/1		Location - City or To lkridge, N	
permit. Departments any inju		21. Signature of Juneral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. D			Inc. 21222
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heartfailure. Liet only one cause on each line.				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Effusion			Oriset and Death
Examiner						
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				u propried
be executed sician and burial-transit	Exar	resulting in death) Last C. Due to (or as a consequence oi):				
flicate by	edical	d				
Physician: The law requires that the death certificate be executed trins certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time ol death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
w requires that been signed b should be deta	þ	Part II, Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobace	co use contribute to the	ne cause of death?
Physician: The law re rths certificate has bei	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
cian: entific	Be (25. Was case referred to medical examiner?		h (Check only one)		
Physic rthis or ral dire	2	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		me 5 Residence	e 6 Other (Specif	y)
f fe a	ation	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation		200. 00001100 11011	njary coodinod	
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Iarm building, etc. (Specify)	street, lactory, office	28I. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
To the Hospital within 24 hours of the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, ir investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
Within To t	Σ	29b. Signature and title of certifier	29c. License number #CC 5442	4 2	Date signed (Month,	Day, Year)
10		30. Name and address of person who completed cause of death (flem 23a) (Ty	Po Hoc 5442 pe, Print) onium Vol. Suita	=#Zc9"	monium	-,MD 21093
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 7 2006 32 Registrar's Signature	Said !			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** KATHERINE LORRAINE GRIMES FEB 2006 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2934 BLACKS SCHOOLHOUSE RD. TANEYTOWN CARROLL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 215-42-6988 62 7/4/1943 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Show of Health and Mental Hygiene. Item 27 is marked other then "neture!", or items 23s or 28s-1 show other treumatic event, the Medical Examinar must be mutilied at 1 ☐ Yes 2 No Director FINKSBURG MD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2828 PATAPSCO 21048 USA Funeral RD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) BEAUTY SALON BEAUTICIAN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be LYDIA ELIZABETH THOMPSON MARSHALL E. KNIGHT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROLAND E. GRIMES -HUSBAND 2828 PATAPSCO RD., FINKSBURG, MD. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If its any njury or of 1 Donation 5 Other (Specify)

PATAPSCO UMC CEMETERY 2/16/06 PATAPSCO, MD Fureral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME E. MAIN ST., WESTMINSTER, MD. 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition **Physician** u resulting in death) /Medical Examiner Esquentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FÉMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of defivery 3 Ectopic pregnancy ō Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SONS 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident ofter death Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m W. Ohrittetin mo D25443 30. Na and address of person who completed cause of death (Item 23a) (Type, Print) MIDDLETON, JOHN W. MD 688 POOLE RD., WESTMINSTER, MD. 21157 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day Year Physician GORDON AMES FEBRUARY 10:02A 14,2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 12M 20 F 88 Yrs. 3-03-7330 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23s or 28s-1 show any Injury or other traumatic event, the Mudicial Explainment unable notified at once. 1 Yes 2 100 BACTIMORE BALTIMORE WD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 3408 RO LAMBROS Funerai 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SHIPPING IERK 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET GORDON ၉ IAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD 21234 30 GORDON JUSEPH SON 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition FEBRUARY 1 Burial 2 Cremation 3 Removal from State ARKVILLE YARKWOOD CEn. 16,2006 4 ☐ Donation 5 ☐ Other (Specify) EVANS HAPEC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UNERAL RD MO HARFORD 8800 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year ģ Month 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ☐ Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CONGESTIVE HEART FAILURE autopsy performed? Yes 2 No page 2 s 1 🗌 Yes 1 Yes To the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical examiner? Medicai Certification; To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 1 ☐ Yes 2 No 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No n 24 hours after death.

ns Funarel Director: A

bletely filled in by the fu death. 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 D 59855 who completed cause of death (Item 23a) (Type, Print) 41 OSLER DRIVE TOWSON MARYLAND 21204 agistrar's Signature 76.211 32. Regie 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Departm State of Maryland / Departm Certific	ent of Health and Mate of Death	ental Hygie	JUUN 1	14656
п	25	45	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Bernardo Garcia		February	12, 2006	11:54 P M
	Examin			City, Town, or Location of Death		4c. County of Death Baltimon	
	3	X		nder 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign
	Funeral Director		460–26–4488 XX M 2 F 83 Yrs.		July 18,	1922 Texa	intry)
			Usual Residence of Decedent				
	ehow dat	-	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Middle Rive				10d. Inside City Limits 1 ☐ Yes XX No
	the M	ecto		. Zip Code	10a.	Citizen of What Cou	intry?
	within 72 hours after death with the Maryland ene. than "natural" or items 23e or 28e-f show the Modical Examition in the modified at	Funeral Director	51 Longeron Drive	21220		J.S.A.	- /
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1943— If Yes,	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
٥	or Its		1 Never Married 20 Married 10 Married 11 Never Married 20 Married 11 Never Married 11	es 2 No Specify:		Specify:	
0500-c	hours ural',	d by	3 Wildowed 4 Divorced Year or Dates:	Mex Usual Occupation	kican	Me b, Kind of Business/l	exican
<u> </u>	in 72 "nat	olete	(Specify only highest grade completed) (Give kind of life. DO NO	osual Occupation If work done during most of worki IT use retired)	ng		idustry
7	d with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Soldier		J	U.S. Army	
2	be filed within tral Hygiene. I other than event, Ing M	Bec	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	den Sumame)	
yland	2 should be and Menta Is marked raumatic ev	2	Deloros Garcia	Guadelupe			
Mar	12 sh h and 7 Is m traum			dress (Street and Number or Rura eron Drive, Balt			
e,	1 and Healt em 2		20a. Method of Disposition 20b. Place of Disposition	(Name of		c. Location - City or	
ב ס	ages ant of ht: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill M	Mem. Gard.Feb.1	7.2006 Ba	ltimore, M	Marvland
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumatic ev 2000.			ne and Address of Facility Bruzdzinski			
ñ	P T C S		1407	Old Eastern Av	venue, Es	sex, Mary	land 21221
			23a. Part Enter the disease, or complications that caused the death. Do not enter the strick, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR Due to (or as a consequence of):	ARRHYTH.	MIA		Immediate
	/Medical Examiner		Due to (or as a consequence of):	TERY DIS	MRE		1007
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	TERY VID	EASE		1787
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
o	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
P8/P0	hysic the bu	dlcal	d				
	death certificate e attending physid for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
ROX	atten atten I for u	clan	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ector	pic pregnancy or (specify)		Month	Day Year
o.		hysl	9 Unknown		/ 1	<u> </u>	
ກົ	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobac	co use contribute to	
ecords,	w require been sig should b		Typertension		1 🗌 Yes	2 No 3 Pro	obably 4 Unknown
ပို	The law requires that the ste has been signed by th page 2 should be detache	Completed	Parkinson's Disease		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
Ï		Cou			performed 1 ☐ Yes 2 ☐	d? death? XNo 1 ☐ Yes	2 No
Vital	Physician: Th r this certificate ral director, pa	Be	25. Was case referred to medical examiner?		Check only one	4 F304 40	
o	Phys r this aral dir	: To	27. Manner of Death 28a. Date of Injury 28b. Time of	DOA Other: 4 Nursing Ho 28c. Injury at Work?	me 5 Nesidenc 28d. Describe how		ory)
0	nding fith. :: After e funer	atlor	1XX atural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M				
Division	Attendi er death. ector: A by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
ō	ital or irs aft ral Dii	Cer					
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Check only (ne) (Check only one) Check only (ne) Chec				
	o the	Med	29b. Signature and title of certifier	29c. License number	29d	. Date signed Monti	n, Vay, Year)
	+ 3 + ō		I farm I (D l best	no 0474	112	02/13	12006
, 1	1		30. Name and address of person who completed cause I death (Item 23a) (Type, Print)	Sharon F	. Diho.	54//	
1,	7		4924 Campbell Blvd Suite 2	00 Balti	ñore m	D 212	36
1	Sta Registi		31. Date filed (Month, Day, Year) / 32 Registrar's Signature		1		
9535	1.09151		FEB 1 7 2006 Believe 15 1900				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2006

32. Registrar's Signature

		-	For State Registrar	State of M		epartment of Certificate	of Health and I		ene 0 0 6	04658	
	in jan		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic	al	Roderick Dougla					February	14 2006 4c. County of Death	12:05A M	
	Examin	er	4a. Facility Name (If not institution, give s Sunrise Brighton G				wn, or Location of Deatl lumbia	ו		ward	
	Funeral	950	5. Social Security Number 6. Sex	7. Ag	je (In yrs. last birt	hday) If Under 1	fear If Under 24 Hrs. Days Hours Min.	8. Date of Birth	Q Birth	polace (State or Foreign	
8	Director		120-22-1296	M 2□F	82	Yrs. Months D	Jays Hours Will.	Oct. 25	,1923 New	York	
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Location				10d. Inside City Limits	
	Maryline -f sho	tor	Maryland Howard		Co	lumbia				1 ☐ Yes 2 🖾 No	
	th the	irec	10e. Street and Number			10f. Zip Co		10	g. Citizen of What Co		
	ath wil	Funeral Director	7110 Minstrel Way				21045	- and a Van as Na	U.S.A		
	iteme iteme	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 XYes 2 _	•	If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	o Rican, etc.)	Black, White		
036	urs aft ai', or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	THE TT	1 ☐ Yes 2 ∑	No Specify:		Specify: B1	ack	
Maryland 21215-0036	72 hours after death with the Maryland natural; or Iteme 23s or 28s-f show disal Examinet must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a.	Decedent's Usual C	done during most of wo	rking	6b. Kind of Business/	ndustry	
121	within ene. then	du	Elementary/Secondary (0-12)	College (1-4or	5+)	Court Off	,		State Cou	rts	
φ 0	iled lygi ther nt,	0	17. Father's Name (First, Middle, Last)	•			18. Mother's Nar	ne (First, Middle, M	aiden Sumame)		
<u>lan</u>	should be f marked of matic eve	To B	George Gittens					s Payne			
lan			19a. Informant's Name/Relationship (Ty			_	Street and Number or Ro				
e, P	es 1 and 2 of Health a of Hem 27 li		Loretta C. Bailey 20a. Method of Disposition	(Sister	20b. Place of	Disposition (Name	ners Blvd.		Oc. Location - City or		
nor			1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	ry, crematory or othe Pond Cres	matory 2-2	1-2006 M	iddle Vill	age. NY	
Baltimore,	せきせて .		21. Signature of Funeral Service Licens	90	110311						
m	5555 TWIN KNOTTS ROad Columbia, Haryland 21045										
· ·			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or						st,	Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				dement	100		5 years	
r	Examiner				a consequence	01).					
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):					
J	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence	of):					
8760,	cate be executed physicien and s the burial-transit	lical E		4	, , , , , , , , , , , , , , , , , , , ,	,					
9	Physician: The law requires that the death certificate be executed it is certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	ledic						j 10			
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		gnancy	IA	23d. Date of del Month	ivery Day Year	
	t the dea by the a tached to	ysici	1 Yes 2 No VA	4∐Pregnant a 9☐ Unknown	at time of death	5 ☐ Other (spec	cify)				
P.0	res that tigned by	by Ph	Part II. Other significant conditions co	ntributing to death	but not resulting i	n the underlying cau	ise given in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
rds	w requires been sign should be	ed b	Type I Dia	betes	Mel	litus		1 □ Ye	s 2□No 3□Pr	obabiy 4 Unknown	
of Vital Records,	e law re hes ber je 2 sho	Completed	'Hypertens	Sion				24a. Was ar autopsy perform		topsy findings available completion of cause of	
al R	: The cate h		1'	_				1 ☐ Yes 2	No 1 ☐ Yes	2DNo	
Vit.	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	fospital:	ient 2□ER/0	utpatient 3□ DOA	Other	eath Check only one Home 5 Reside	V	city) Living	
l of	ding Physicien: The h. A. After this certificate hi funeral director, page	n: To	27. Manner of Death	28a. Date of In	jury 28b.		c. Injury at Work?	28d. Oescribe ho			
sior	eath. or: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No	006 L 10 /Ct	reet and Number or R	usel Cauta Alumbas	
Division	or Ati	Certification:	4 Homicide determined		njury - At home, to etc. <i>(Specify)</i>	arm, street, factory,	office	City or Town		arai noute Number,	
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medicai Co	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ner: On the basis	of examination at	e, death occurred at nd/or investigation, in	t the time, date and place n my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner at te and place, and due	s stated. e to the cause(s)	
	othe othe omple	Med	29b. Signature and title of certifier	and manner s	M, D	29c.	License number	29	9d. Date signed (Mon	h, Day, Year)	
)	N - 3 - 3		•	h.	1. 1.	CT on Polon	> 5653 Rd, Ca)	zeb 15	, 2006	
	13		30. Name and address of person who de Harrij Li	TRO H	tick-0 ry	Ridge	Rd, ci	olum bia	, mDs	21044	
务	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 7 200	See	trar's Signature	freite					

MARIBETH

GEISS

			1 - For State Registrar	State of M	1aryla				lealth a D <i>eath</i>	nd Me	_	giene	00	6	046	559
3	Physic	ian	1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	,	Year		of Death
1	/Medi		Maribeth Geiss								Feb	13	2	006	1.1	5 P. M
	Exami	ner	4a. Facility Name (If not institution, gives	HOSPITT	AL		BA	LTI	MORE				County	of Death		
2	Funeral Director		5. Social Security Number 6. S 504-52-2246 Usual Residence of Decedent	Sex 7. A	ge (In yrs 60	. /ast birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 1/31	th 19. Year) 194	6	9. Birthp Coun Flor	lace (State try) ida	or Foreign
	show		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside	City Limits
	a-f st	ctor	MD Baltimon	re		Cat	onsv	ille							1 🗆 Ye	s 2 No
	or 28	Dire	10e. Street and Number				10f. Zip							Vhat Coun	try?	-
	s 23e	era	2403 Harborwood I	Rd . 12. Was Deceden	. Consider	15 40			21228		7 V N		S.A			
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mydical Examinat must be notified at	Completed by Funeral Director	11. Marital Slatus 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No		f Yes, spe	,	Specify:	Puerto R	cify Yes or No lican, etc.)	•		e - Americ k, White, d		
20	72 ho	ted	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usua	al Occupa	ation furing most	of workin	2	16b. Ki	nd of Bu	siness/Inc		
121	within ne.	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired)	OF WORKIN	g	_				
d 2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last,	5+		Te	eache	r	18 Mother	's Name	(First, Middle,			ation		
Maryland	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, in M	To Be	John Deibert 19a. Informant's Name/Relationship (105 14-18			Maria	an Oc	hs					
Ma	and 2 s salth an n 27 ls r		Mariangela Weisko		iter						Route Number			State, Zip	Code)	
Baltimore,	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	,	Place of Dispo	natory or o	ther place	,	Da				City or To		
Baltir	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra QDCE.		21. Signature of Funeral Service Licer		exel.	7 22	. Name ar	d Addres	s of Facility	Ster	ling-A nsvill 21228	shto	n-S	chwab	-Wit:	zke
0, <	Physician /Medical Examiner putality and physicien and phy	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, п алу, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each	E A I	RACHI								E	Approxim Inierval B Onset and	etween d Death
P.O. Box 68760,	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ¶o 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	al death 3 death 5 death	Ectopic pro	ecify)	n in Part i		23e. Did to		Mon		Day	Year
ords,	w requires to been signer should be	ted by					- Idenying G		mairants.			/es 2[3 Proba		Unknown
Division of Vital Records,	The lay ate has page 2	Completed											d d	rior to con eath?	sy finding pletion of 2 No	s available cause of
Ξ	Physician: this certificant	o Be	25. Was case referred to medical examiner?	Hospital:		1		Othe	_		Check only o					
on of	ding After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	12 Inpati 28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	4 🗆 Nurs	28	e 5 Resid)	
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		jury - At h tc. <i>(Specii</i>	ome, farm, stre					If Location (S City or Tow		l Numbe	er or Rural	Route Nu	m <i>ber</i> ,
	ne Hospital or n 24 hours after ne Funeral Dir bletely filled in I	ledical C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best niner: On the basis of and manner st	or examina	owledge, death tion and/or inv	occurred estigation,	at the time	e, date and inion, death	place, an	d due to the d d at the time, d	cause(s) date and	and mar place, a	nner as sta nd due to	ated. the cause	(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	un 1	ID		290	: License	number 176	02			_	(Month, E		
	10		30. Name and address of person who is KOLLT RAM	completed cause of o	death (Iter	n 23a) (Type, F	Print)	AVE	E , B/	4671	MORE	, r	ID.	- 215	228	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	-	ature	de									

MD BALTIMORE CATONSVILE 10, Zip Code 10, Citizan of What Country? 11, Was Decedent Five in U.S. 12, Was Decedent Ever in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Ever in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 13, Was Decedent Five in U.S. 14, Page of Code, White, etc. 15, Decedent Five in U.S. 16, Decedent Five in U.S. 17, Was Decedent Five in U.S. 18, Back, White, etc. 10, Ves 28, Wo performance in U.S. 11, Was Decedent Five in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 13, Was Decedent Five in U.S. 14, Was Decedent Five in U.S. 15, Was Decedent Five in U.S. 16, Decedent Five in U.S. 16, Decedent Five in U.S. 17, Was Decedent Five in U.S. 18, Back, White, etc. 10, Ves 28, Wo performance in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 14, Was Decedent Five in U.S. 15, Was Decedent Five in U.S. 16, Decedent Five in U.S. 17, Was Decedent Five in U.S. 18, Was Decedent Five in U.S. 18, Was Decedent Five in U.S. 19, Was Decedent Five in U.S. 10, Was Decedent Five in U.S. 11, Was Decedent Five in U.S. 12, Was Decedent Five in U.S. 14, Was Decedent Five in U.S. 15, Was Decedent Five in U.S. 16, Decedent Five in U.S. 16, Decedent Five in U.S. 17, Was Decedent Five in U.S. 18, Was Dece				Please	Type or Print in I				•	_).
Physician informatic hamiltonic provision and number) South Agrees Hospital A	(in the second			1 - State Registrar						ZUU5	04660
## County of Death Security Number County	A	Physic	an		st)				Month		ar
Funeral Directors Social Security Number 0.000	Ы				re street and number)	4b.	City, Town, or Loc		ebruary		
Second Company Compa		Funeral	ier	Saint Agres 7 5. Social Security Number 6.5 220-22-2190	OSp tal 7. Age (In yrs.	last birthday) If U	Balhmo I	Under 24 Hrs. 8	(Month, Day, Y	N 9.	A Birthplace (State or Foreign Country)
I Yes, specify Cuban, Mexican, Puerfo Rica, etc.) Black, White, etc.		yland now			10c. Cit	ty, Town or Location	1				10d. Inside City Limits
I Yes, specify Cuban, Mexican, Puerfo Rica, etc.) Black, White, etc.		sa-f et	ctor	MD BALTIM	ORE CAT	ONSVILLE					1 ☐ Yes 2 🔯 No
I Yes, specify Cuban, Mexican, Puerfo Rica, etc.) Black, White, etc.		with th				10			10g		•
I Yes, specify Cuban, Mexican, Puerfo Rica, etc.) Black, White, etc.		ne 23	erai		12. Was Decedent Ever in U	S 13 Was F		nic Origin? (Specif	y Yes or No-	7	
15. Becorder of State	9036	ours after rai', or ite	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes,	specify Cuban, M	lexican, Puerto Rio	an, etc.)	Btack, W	hite, etc.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Madden Sumame)	15-0	"natu	letec	15. Decedent's E- (Specify only highest gra	ducation ade completed)	(Give kind o	of work done during	g most of working	161	b. Kind of Busine	ss/Industry
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Madden Sumame)	12	withir iene. than	dmo						Q	אמוםו 9	TOLOTTY
Approximate Sequentially ist conditions and plant plant of the sequence of: Approximate Sequence of: Approximate Sequence of		e filed al Hyg other				VELCE	11 4	Mother's Name (F			Beurity
WANDA HOLLY. COLEMAN 342L ASCOT CT., WOODBRIDGE VA 22192 20a. Method of Disposition 18-Burial 2 great of September 19-Burial 2 great of September 2 great of September 2 great 19-Burial 2 gre	ylaı	ould b Menta arked atic e					FA	ANNIE E	BROOKS		
200. Method of Disposition 1 & Burial 2 Cremation 3 Removal from State 4 Donation 5 College (Special College C	Mar	d 2 sh th and 7 Is m traum			** **	19b. Mailing Add	fress (Street and N			ity or Town, State	e, Zip Code)
16 Squaria 2 Coremation 3 Removal from State GARRISON FOREST 02. 22. 06 OWINGS MIUS MD		s 1 an f Heal fem 2 other		· · · · · · · · · · · · · · · · · · ·	20b. F	Place of Disposition	(Name of			VA 22 c. Location - City	or Town, State
Separation Sep	E O	Page: net o int: If I			Hemoval from State			02.22.	06 01	umas	CIM SUIM
23a. Part I. Entito Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Medical Examiner Immediate Cause (Final Medical Examiner)	Balti	permit. Departn Imports any inju				VAUGH	ne and Address of	Facility FUNE	RAL SER	VICE	MIGS IND
Sequentially list conditions, if any, leading to immediate cause. Enter Unmediate cause. Enter Underlying Cause Disease or injury that minimate devents resulting in death) Last Due to (or as a consequence of):				Immediate Cause (Final disease or condition	a. In ha crani	h. Do not enter the	mode of dying, su	ich as cardiac or re	espiratory arrest,		Interval Between Onset and Death
The proposed of the proposed o	§ 1	Examiner			Due to (or as a consequ	uence or):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Due to (or as a consequence of): Comparison of the companies of the co	7	고 #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	uence of):					
Sylvanian and the state of the	٧	and and il-trans	xam	that initiated events	c. Due to (or as a consequ	uence of):					
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		ss that gned b	oy P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlyi	ng cause given in	Part I.	23e. Did tobac	co use contribute	to the cause of death?
	ord	equire sen sig	ted						1 🗆 Yes	2 2 No 3 □	Probably 4 Unknown
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26. Place of Death (Check only one)											
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27. Manner of Death 1	Sio	tendii Jeath. tor: Ai the fu	catic	2 Accident investigation		M	1 🗆 Yes	2 🗆 No			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	Divi	lor At after of Direct In by	ertifi		286. Place of Injury - At ho	ome, farm, street, fac y)	ctory, office	28f.			Rural Route Number,
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		To th within To th compl	Me	29b. Signature and title of certifier			29c. License num	nber	29d.	Date signed (Mo	nth, Day, Year)
Mohammed P17601 February 14, 2006)			Moham	med		P1760	1	Fe	brua	14 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		10								·	
Neversa Mohammed 900 S. Caton Avenue Baltmore, MD 21229 State 31. Date filed (Month, Day, Year) 32, Registrar's Signature		Sta	te "			ture		3altimore	MD	21229	
Registrar FFB 1 7 2006 Assess Assessed				FEB 1 7 20		A	9				

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			1 - For State Registrar		f Maryla	nd / Depa		nt of H te of L				Reg. No.)6	04661
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	Funeral		BACT MORE WA 5. Social Security Number 6	Sex	7. Age (In yrs	a. last birthday)	If Und	er 1 Year	If Under 24	4 Hrs.	8. Date of Birt	th	ARUI 9. Birtholi	
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au	id be ental ked c	To Be	100 100 100 100 100 100 100 100 100 100	· UKII•								ifflett	,,,,	
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Marylan and Mental Hyglene. Is marked other than "natural", or iteme 23a or 28a-f show aumatic event. The Madical Examinar must ke notified at	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Street a	nd Number	or Rurai	Route Numbe	er, City or Town,	State, Zip (Code)
Ξ	5 = 2 =		Pauline Grimes	(Daught	er)	306	Made	line	Ave.	Gler	n Burni	ie, MD	21060)
ore	m O L		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from 9	I	Place of Dispo	sition (Na natory or	ame of other place)	Da	te	20c. Location -	City or Tov	wn, State
Ĕ	Pages ment of I ant: If its		4 Donation 5 Other (Specialist			ak Lawn	Cem	etery	2/17	7/200	06	Baltim	nore,	Maryland
Baltimore,	permit. Page Depertment of Important: If any injury or once.		21. Signatur of Funeral Service Lic	ensee	2		. Name a uda-	ind Addres Ruck	s of Facility Funera	al Ho	ome of	Dundalk	, Inc	·
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Emai			itii. Do not ent	er trie mo	de oi dying	, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
ķ.	Physician /Medical		disease or condition resulting in death)		PSis								13	2 HOURS
	Examiner			10000	or as a conse		1- 1	1100	ctio	.,			^	2440
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a conse	quence of):	CR	MEE	C110	h			•	2 DAYS
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۷/pn, ۷	oe exection a	E	resulting in death) Last	Due to (d	or as a conse	quence of);								
200	death certificate be executed e attending physicien and id for use as the burial-transit	dical		d									-	
Š Š	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregn	ancy						22d Dot	o of deliver	
XOD .	death a atter d for u	clar	in the past 12 months?	1 ☐ Live bi	nth 2 ∐ Fet untat time of	aldeath 3□	Ectopic p Other (s	pecify)				Moi	te of deliver nth	y Day Year
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ecord	w requir been si should i									_	1 🗆 Y	es 2□No	3 Proba	bly 4 Munknown
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	cate he										perfor 1 ☐ Yes		death?	No
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DIVISION	el or Attending P s after death. il Director: After t id in by the funera	ertificati	3 Suicide 6 Could not determine	d 286. Place	of Injury - At h	iome, farm, stre	eet, facto	ry, office		28	f. Location (S	treet and Numb	er or Rural	Route Number,
5	rs after or rate or rate	Cert	4 Citioniado	Builder	g, etc. (Speci	·y/					City or Tow	m, State)		
	To the Hospitel or Al within 24 hours after To the Funeral Direc completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying F	Physician: To the to miner: On the bar and manner	sis of examina	owledge, death ation and/or inv	occurred estigatio	at the time	e, date and pinion, death	place, an occurred	d due to the d at the time, d	ause(s) and ma date and place, a	nner as sta and due to t	ted. the cause(s)
ı	To the To the comp	Me	29b. Signature and title of certifier				29	c. License	number		1	29d. Date signed	(Month, D	ey, Year)
			Octivarina). G	M ccolynia	0		1	0006	2714	_	1	PEBRUAG	24 13	> 200€
	6		30. Name and address of person who	/ _ ^		m 23a) (Type,	Print)		. \					
	-		31 Date filed (Month Day Year)		ECO gistrar's Signa	301 H	ospit	114	DRIVE	JB c	EN BU	RNIEJH	10,31	1901
	Sta Registra	ie ar	31. Date filed (Month, Day, Year), FEB 1 7	2006	Signal 2 Sign	A A	346	,						

DHMH 17 Flev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hasselberger Month **Physician** Year 12:30 CM 2006 Ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Bayview Care HOPKINS N/AIf Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 200 F Yrs. Director 81 220-22-7430 31,1925 South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 1914 Oxley Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Clark Edna M. Clarke 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Darrel Hasselberger 539 Fuselage Ave. Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Dep.rtment o Important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/17/2006 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Luda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part T. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumon DAYS /Medical Due to (or as a consequence of): Obstructive Relmonary Disease **Examiner** VEACS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician an/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Physici ☐Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an No 1 Yes of or Attending Physician: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P Inpatient filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State

Hopkins

Bayview Circle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2006

5505

Registrar's Signature

Richard Marcinko

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month HARPER ORNEUA 134 FEBRUARY , 2006 /Medical n, give street and number) Bayuew Ma 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BALTIMORE
If Under 1 Year | If Under 24 Hrs. Modicic Genter Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2505 220-01-1593 Yrs. Director 19,1914 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yes 2X No Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 3404 Yorkway United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No δ Specify 3 □Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Important: If Item 27 is marked other til eny injury or other traumatic event, the once. Restaurant Waitress 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Keliman Theodore Pacurar 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 3404 Yorkway Mr. Michael Alford (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Baltimore National Cem. 2/21/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and thed for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 4☐Pregnant at time of death 5 Dther (specify) P.0 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 22 No 21 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending is within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-60 1 MDTHUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LYLE W. OSTROW MD PND, 4940 EASTERN AVENUE, BALTIMORE, MARTELLY, 21224 31. Date filed (Month, Day, Year)

State Registrar

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2006

			1 - For State Registrar	State of Ma	ryland		artment rtificate				-	giene	UUD	04664
	• Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Dea	ath Day	/ Year	3. Time of Death
	/Medic			BETTY MA	E HUI	NTER					02	16	04	0600 AM
	Examin	er	4a. Facility Name (If not institution, give si		_				Location o			4c.	County of Dear	
			CARROLL HOSPITA 5. Social Security Number 6. Sex		(In yrs. last	t hirthday)	WES'.		ISTER		8. Date of Birt	h	CARRO	ப்.ப thplace (State or Foreign
ŀ	Funeral Director		-	M 2X7 F	80	Yrs.	Months		Hours	Min.	(Month, Da)	y, Year)	Co	STLAND
	P		Usual Residence of Decedent								IAI ZI	, 10	25 MAIN	
	arylar show	7	10a. State 10b. County MD CARROLL		10c. City, T זגוניד			,						10d. Inside City Limits 1 ☐ Yes 2000
	he M	ecto	MD CARROLL 10e. Street and Number			MII	IDSOR					10 0::	(110	
	with t	급	1423 HALLOWELL	T.ANE			10f. Zip	177	6			-	zen of What Co USA	ountry?
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9	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No							ify Yes or No- lican, etc.)		Black, Whit	
21215-0036	rel', c	t by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2	210 No	Specify:				Specify: WH	ITE
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12	within lene. then "	I di	Elementary/Secondary (0-12)	College (1-4or 5+)			OO NOT us IOUSE					ном	E MAKE	:R
	filed Hygie ther ant,	ပိ	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,			
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	and 2 salth a n 27 ls		NANCY L. STOREY	-DAUGHT	ER 1	423	HALL	OWE	LL L	ANE,	NEW W	IND	SOR, M	D. 21776
ore	of He		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	moval from State	20b. Place ceme	e of Dispo: etery, cren	sition (Nam natory or ot	ne of ther place)	Da	ite		cation - City or	
Baltimore,	Pages tment of tent: If it		1 XBurial 2 □ Cremation 3 □ Re (4 □ Donation 5 □ Other (Specify)	M	EADO									ER, MD.
Baj	permit. Pag Department Importent: t any injury o		21. Signsture of Funeral Service Licensed	•									NERAL TER, M	HOME D. 21157
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Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 Live birth 2	Fetal de	ath 3 🗌	Ectopic pre					2	23d. Date of del Month	ivery Day Year
o.	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it.	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown	ne or deatr	n 5L	Other (spe	эспу)						,
۵.	that	y Ph	Part II. Other significant conditions conti	ibuting to death but	not resultin	ng in the un	nderlying ca	use give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
rds	quires n sign	ed by									1 🗆 Y	es 2[□No 3□Pr	obably 4 Unknown
000	s bee	Completed									24a. Was		24b. Were au	topsy findings available
ž	The fate had bage	E O									autop perfor		death?	completion of cause of 2□ No
ıta	sien: artifica ictor,	Be	25. Was case referred to medical examiner?								Check only or	ne)		
5	hysic this ce al dire	P	1 □ Yes 2 No	spital: 1 Inpatient		/Outpatient		A Othe	r. 4□Nur				Other (Spec	cify)
nc	ling P	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	'ear) 281	b. Time of Injury		Bc. Injury Work			ld. Describe h	ow injury	occurred /	
Division of Vital Records,	death death ctor: , the i	licat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home	farm stre	M et factory		es 2□N	-	of Location (S	treet and	d Number or Ru	ral Route Number.
2	after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	, 141111, 3(1)	out, ractory,	, 011100			City or Tow			a riodio ridinber,
	pspite hours nerel y filled		29a. Certifier 1 Certifying Physic	cian: To the best of	my knowled	dge, death	occurred a	it the time	e, date and	d place, an	d due to the d	ause(s)	and manner as	stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examine one)	or: On the basis of ea	kamination	and/or inv	estigation,	in my op	inion, deat	h occurred	at the time, o	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				1	License			2	29d. Date	signed (Month	n, Day, Year)
)			- Buth					02	1942			C	2/16/	06
	3		30. Name and address of person who com					14 5		1.1.				21157
	Sta	te	SARVA GIRDHAR 31. Date filed (Month, Day, Year)	295 g			AVEN	WE		_ WE	521 WI	N 27	EK W	ARYLAND
*	Registra		FEB 1 7 200				nack i	þ						
			·	V A STANSON AND A STANSON	1	200	ALC: The second							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar		artment of Health and I rtificate of Death	Mental Hygien	000 04000
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medic		FLORENCE G. HOP	WOOD		FEBRUARY	16 2006 2-30 M
	Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Death	1 '4	c. County of Death
			Northwest Hospital Co	nter	Randallstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore State or Familia
П	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs. last birthday)	Months Days Hours Min.	Month, Day, Yea	or) 9. Birthplace (State or Foreign Country) 5.1920 Maryland
	Director		Usual Residence of Decedent	. 0.5	31	eptember 0.	1920 Haryrand
	how		10a. State 10b. County	10c. City, Town or Lo	ecation		10d. Inside City Limits
	e Ma 3e-f s	cto	Maryland Baltimore	Reisterst			1 ☐ Yes 2⁄☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	e 23s	erai	304 Cantata Court 11. Marital Status 12. Was	Decedent Ever in U.S. 13.1	21136 Was Decedent of Hispanic Origin? (S		ed States of America
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itame 23a or 28e-f show any fujury or other traumatic event, The Medical Exartir at must be notified at ance.	by Funerai	1 Never Married 2 Married 1 Yes	d Forces? ′es 2 M No s, Give	f Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2∰ No <i>Specify:</i>	o Rican, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	hour: tural'	ed b	3 XXVidowed 4 ☐ Divorced Year 15. Decedent's Education	or Dates:	dent's Usual Occupation	16b.	Kind of Business/Industry
15	n "na Nedic	piet	(Specify only highest grade comple	ted) (Give	kind of work done during most of wor DO NOT use retired)	king	
212	d with giene	Completed	12		Dresser		llth & Beauty
p	al Hy al Othe	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	
yla	Ment Ment arked	ပ္	Franks L. Snoops			e D. Pfiefe	
Nar	12 sh h and h and 7 Is m rreum		19a. Informant's Name/Relationship (Type, Print,	0200000	ng Address (Street and Number or Ru	750 E S	100000 may 1000000000000000000000000000000000000
e,	1 and Healt em 2		Diane Emmons 20a. Method of Disposition	20b. Place of Dispo	June Berry Court	Reisters Date 20c.	Location - City or Town, State
nor	ages ant of t: If it		XXBurial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State	natory`or other place) Memorial Pairk 03	7/17/06 Svh	esville, Maryland
Baltimore,	artme orten injur	ı	21. Signature of Funeral Service Licensee		A STATE OF THE PARTY OF THE PAR	and the second second	Funeral Directors, In
ñ	Depa Impo any is			or MO0333 8	728 Liberty Road,	Randallst	own, Maryland 21133
			23a. Part1. Enter the disease, or complications t	hat caused the death. Do not ent on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1 D	FAILURE '		Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):		^	L 110 com o'
		-	Sequentially list conditions, if any leading to immediate	e to (or as a consequence of):	EVINALOVATHY SI	MACHOS	to URGAMIA'
J	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	COROMARY	AKTERY D	ISEMSE '	
,	exection and and rial-tra	Еха	resulting in death) Last Du	e to (or as a consequence of):			
8760,	death certificate be executed attending physician and od for use as the burial-transit	dical	d	DIAB	ETES MELL	1745	
9	artifica ing ph e as t	Med	IF FEMALE:				
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
P.0.	res that the de igned by the a be detached f	by Physician/Me		regnant at time of death 5 [Inknown	Other (specify)		
	that the led by th detache	y Ph	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Division of Vital Records,	law requires as been sign 2 should be	q pe				1 🗆 Yes	2 No 3 Probably 4 Unknown
CO	aw require s been sign	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	9 L B	mo				performed?	death?
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			ath (Check only one)	
) t	Physicien: r this certific ral director,	ို	1 ☐ Yes 2 No	1 Inpatient 2 ER/Outpatier		lome 5 Residence	
nc 0	ling P	lon:	1 Natural 5 Pending	Date of Injury 28b. Time of Month, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	gury occurred
isic	death death ctor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be 28e.	Place of Injury - At home, farm, str			and Number or Rural Route Number,
Ο̈́	after Dire	Certification:	4 Homicide determined	ouilding, etc. (Specify)	,,	City or Town, Sta	ate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific completely filled in by the funeral director.	Medical C	(Check only 2 Medical Examiner: On t		n occurred at the time, date and place vestigation, in my opinion, death occu		
	o the	Mec	29b. Signature and title of certifier	1	29c. License number	29d. [Date signed (Month, Day) Year)
	r ≥ + ŏ		goginda P	melle mo	D41410	Feb	murry 16", 2006.
	h		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print) LOGINDER F	MEHTA	
_			MORTHWEST HOSP	7m CENTER	A		21133.
	Sta		31. Date filed (Month, Day, Year) FEB 1 7 2006	32. Registrar's Signatur			
	Registr	al	LED T . TOOL WAS	and a			

			1 - For Stete Registrer	State of Ma	aryland	-			lealth a Death	ınd M	ental Hy	giene Reg. No.	000	5 (04667
	Dhysia	0.0	1. Decedent's Name (First, Middle, Las	1)							2. Date of De Month		Ye		3. Time of Death
	Physici /Medi		Patricia Ann Hogan								Februa		5 200°		02:10 a M
	Examir	ner	4a. Facility Name (If not institution, give			. 0.16		, Town, oi WSON	r Location o	f Death			County of D altimo		
			Greater Baltimo: 5. Social Security Number 6. Se	7. An	e (In yrs. la:			r 1 Year	If Under 2	24 Hrs.	8. Date of Bir				ce (State or Foreign
	Funeral Director		214-30-3271	_M 2 ₹ F	72	Yrs.	Months	Days	Hours	Min.	8. Date of Big (Month, Da Feb. 27	1933.	3 Ba	Country	nore,MD
			Usual Residence of Decedent		10-01-	~									
V	anylar show	2	10a. State 10b. County	· · · Co		Town or Lo	ocation							100.	. Inside City Limits 1 ☐ Yes 2X No
CIP	vith the Maryle or 28a-f sho	ecto	Maryland Baltimor	.e co.	Gry	ndon	10f 7i	o Code				10a. Citi:	zen of What	Country	
	with with	בַּ	3402 Tufton Ave.				101. 2	210	171				nited		
	death ms 2;	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13.	Was Dece			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - A	merican	Indian,
7 9	after or its	F	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 241 If Yes, Give	No		ır res,spi 1 ☐ Yes		Specify:	, Puerto	nican, etc.)		Black, W Specify:	mite, etc Whit	
PATRI 1215-0036	within 72 hours after death with the Maryland ane. Then "naturel", or Items 23a or 28a-f show na Medical Examinational be notified at	Completed by Funeral Directo	3 Widowed 4 Divorced	Year or Dates:											
Q 15	n 72 nat	lete	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Dece (Give life.	kind of w	ar Occup ork done d ise retired	ation during most f)	of worki	ng	160. Kir	nd of Busine	ss/indus	stry
212	_ = _ =	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		me Ma						Own	Home	9
工管	e filed wi al Hygien other th	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
₩ ×	should b ind Mente marked	10	John J. Luby, Jr.								Satter				
A Par	2 sho and ie m		19a. Informant's Name/Relationship (T				-				Route Numb				ode)
T 0	1 and Heelth em 27 ther t		Mrs.Carol Lynn Nev	vcomb (Dau	20b. Pla	ce of Disno	sition (Na	me of	ı		Sel Air	·	2101 cation - City		n. State
JA ARTI	ages ont of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cen	netery, crei	matory`or	other plac	e) 161 F	'eh. 1	.6,2006				
HOG ARTH Baltimore, Maryland	permit. Pages 1 and 2 should be filed Deperment of Heelth and Mental Hyg Important: If flem 27 ie marked other eny injury or other treumatic event, ance.		21. Signature of Euneral Service Licens		- Avair				1						
I	Page 9		Mar	7. 9	auz,	-4-P	eace:	ul A York	Altern Road	ativ Ti	es Fun Monium	eraib • Mar	xCrema cvland	[tion 2]	n Ctr.P.A. 1093
			23a. Part . Exter the disease, or compositors, or heart failure. List only of	ne cause on leach li	ne.	Do not ent	ter the mo	de of dyin	g, such as	cardiac o				A) In O	pproxi <i>m</i> ate iterval Between Inset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Meta.			Vacio	in (Canc					3.	months
	Examiner			Due to (or as	a conseque	ence or):									
	3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ince of).									
	ocuted nd transi	Examiner	that initiated events	с,											
90.	ite be executed sysicien and he burial-transit	Ë	resulting in death) Last	Due to (or as	a conseque	ence of):									
8760.	5 5 6	dicai		d										T.	
)9 X	- C0 m	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of	delivery	
Box	death a atter d for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic p Other (s						Month	Da	ay Year
O.	t the de by the a	hys	9 Unknown	9□ Unknown									- 1		
S.	res tha igned be det	by P	Part II. Other significant conditions co	ntributing to death b	ut not result	ing in the u	nderlying	cause give	en in Part I.				_		cause of death?
ord	w requir been si should I	Completed			-	-					10	Yes 2	1N0 3L	Probabi	ly 4 ⊠Unknown
ě	elaw hasb	npie									24a. Was		24b. Were prior	autopsy to compl	findings available letion of cause of
<u>e</u>	ilcian: The l certificate ha		Proventing the second		· · · · · · · · · · · · · · · · · · ·						1 Yes		1 🗆 ነ	es 2[□No
<u> </u>	Physician: this certific al director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		D/O		Oth	00		(Check only				
ō	Phys ar this aral di	. To	27. Manner of Death	28a. Date of Inju	ıry 2	R/Outpatier 8b. Time o		28c. Injun Worl	4 1401		ne 5 ☐ Resi 28d. Describe			рөсігу)	
ö	Attending Physician: r death. sctor: Atter this certifica by the funeral director,	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury	м		K? Yes 2 □ N	10					
Division of Vital Records.	or Attendate after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	e, farm, str	reet, facto	y, office		3	28f. Location (City or To			Rural R	Poute Number,
۵	To the Hospital or Attu within 24 hours after de To the Funerel breact completely filled in by th			sicien: To the best											
	n 24 h	Medical		iner: On the basis of and manner sta	f examinatio										
	To th Withir To th comp	ž	29b. Signature and title of certifier	1 ^					number				signed (Mo		
	, 4		Daved 1 1h	ull m	0			200	628	03		Febru	uary	16	2005
	41		30. Name and address of person who of			^	Print)	.1	c.1	/	Sa Itim		MA	-1 -	2 10 []
		to.	31. Date filed (Month, Day, Year)	32. Regi	656° ar's Signatu	re	Cha	162	57.		26 177m	ore	1110	216	707
	Sta Registr			2006	Latinar 1	M	A STATE OF								

0	j	p	got .	6
U	LL	O	O	(

			Certificate of	f Death	Re	g. No.	04000
	1. Decedent's Name (First, Middle, Las	et)			2. Dete of Deeth Month		3. Time of Death
Physician /Medical	Harold	Richard	Hartge		February	7 15,2006	9:27 AM
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Deeth	4c. County of Deet	h
	3701 White Pine Ro			Middle Ri		Baltimo	
Funeral Director	5. Social Security Number 6. Social Security Number 11 6. Social Security	ax 7. Age (In) ☐ M 2☐ F	yrs. last birthday) If Under 1 Yea Months Dey		8. Date of Birth (Month, Day, Oct 22,1	Year) 9. Birt Co 1930 Mar	hplace (State or Foreign untry) vland
	Usual Residence of Decedent	21	, ,		300		
show	10a. State 10b. County	10c	City, Town or Location				10d. Inside City Limits
e Me	Maryland Baltimore		Middle River				1 ☐ Yes 2 ☐ No
filed within 72 hours after death with the Meryland Hygiene. ther than "natural; or items 23a or 28a-f show int, the Medical Examinar must be notified at or Completed by Funeral Director	10e. Street end Number	a a Hell	10f. Zip Code		10	g. Citizen of Whet Co	untry?
ath v	3701 White Pine Ro		I I D I I I D I I I I I I I I I I I I I	21220	aifu Van au Na	USA 14. Race - Ame	rican Indian
Pr de la	11. Merital Status	12. Was Decedent Ever in Armed Forces?		Hispanic Origin? (Spe ban, Mexican, Puerto I	Rican, etc.)	Black, White	
ours after death with the Meryle ali, or items 23a or 28a-f shor Examiner must be notified at by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 AYes 230 No If Yes, Give Year or Detes:	1954 1□ Yes 2⁄Q N	o Specify:		Specify: Wh	ite
led within 72 hours lygiene. ner then "naturel", nt, the Medical Ex Completed by	15. Decedent's Ed (Specify only highest great	ucation de completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	upation e during most of working	ng 1	6b. Kind of Business/	Industry
be filed within 72 no stal Hygiene. Id other than "nature event, the Medical Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesman	rea)		Bever	age Company
T T S	17. Father's Neme (First, Middle, Last)		Darebhan	18. Mother's Name	(First, Middle, M.		4.90 Os.,p. 11-7
n = 0 5 3	Harold W. Har	rtge		Helen	Dee		
permit. Peges 1 end 2 should by Depertment of Health end Menta important; if item 27 is marked any injury or other treumatic events. TO E	19a. Informant's Neme/Relationship (7 Robert M. Hartge	ype, Print) (son)	19b. Mailing Address (Stree 3701 White Pi				
of He of He r othe	20a. Method of Disposition 1 Durial 2X Cremation 3 D		 b. Place of Disposition (Name of cemetery, crematory or other p. 			Oc. Location - City or	
Peg ment ant: i	4 ☐ Donation 5 ☐ Other (Specify) B	ayview Crematory			altimore,	
permit. Depertrimports any Inj.	21. Signature of Funeral Service Licens		/*/	ress of Fecility Bru Eastern Av			
Physician	23a. Part1. Enter the disease, or companies, or heart failure. List only of	ications that caused the c ne cause on each line.	leath. Do not enter the mode of d	ying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
/Medical	Immediate Cause (Final	Dod Chase C	lalawaahal Canaa		- a+	to Tirror	year
Examiner	disease or condition resulting in death)	Due	colorectal Cance (or es a consequence of):		istases_	to Liver	
ē E		Hypertensic	n with Heart Fa	ilure			year
and trens	Sequentially list conditions,	Due t	o (or es a consequence of):			1	
sian e	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	Diverticuli	tis				year
ing physician end e es the buriel-transit Medical Examiner	that initiated events resulting in death) Last	Due to	o (or as a consequence of):				
ding		d					
the attendined for use					l on Pidak		to the cause of death?
d by the attend leteched for us	Part II. Other significant conditions co		resulting in the underlying cause of	given in Pert I.	236. Did tob		obabiy 4 Unknown
y P	Colonic divertic	ulae			1 101	2/29/10 30/1	obably 4 onknown
een signed by the attending physician end hould be deteched for use as the bunel-transieted by Physician/Medical Exami					24a. Was an	ed?	Were autopsy findings available prior to
2 2 5							completion of cause of death?
ete he page					1UYes	2 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical			26. Place of Death	(Check only one)	
this cert al direct	1 ☐ Yes 2 🕍 No		Z EN/Outpatient 3 DOA	other: 4 Nursing Hon		ice 6 Other (Spec	cify)
h. After th funeral	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea			28d. Describe how	v injury occurred	
r death. ector: Afte by the fune	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			□Yes 2□No	not beaution (Ctr	et and Number or Ru	ım I Pouto Number
rs efter death. al Director: After ti led in by the funera Certification:	4 Homicide determined	28e. Plece of Injury - A building, etc. (Sp	At home, farm, street, factory, offic ecify)	9	City or Town,	State)	and House Humber,
within 24 hours efter deati To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, death occurred at the	time, date and place, a	ınd due to the cau	use(s) and manner as	stated.
in 24 hour he Funer pletely fill edical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	nination and/or investigation, in my	opinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
Withii Comp	29b. Signature and title of certifier	Pinl		nse number	29	d. Date signed (Monti	h, Day, Year)
11	Mellen	Keilly	MU D5	4749		February 1	7, 2006
61	30. Neme and eddress of person who co					_	
	Allen Reilly 4 East	t Rolling Cr	ossroads Suite (307 Baltimo	re Md 21	228	
State Registrar	31. Date filed (Month, Day, Year) FFR 1 7 200	. 10	Market Sand				
regiotial	= 17_D 4 1 EUU	U REMEMBER AND A	740				

HAROICH HARTGE

			For State Registrar	State	of Ma	ırylanı	•	artmen tificate			and M	lental Hy	giene	006	04669
	0		Decedent's Name (First, Midd	le, Last)								2. Date of Dea	ath	V	3. Time of Death
	Physicia /Medic		Edna	Нот	ve11							Month 02	14	2006	4:35 P ^M
	Examin		4a. Facility Name (If not institution	n, give street and r	umber)					Location of			4c. C	ounty of Death	1
			Calvert County	Nursing	Home	<u> </u>		Prin					Ca.	lvert	
	Funeral Director		5. Social Security Number 217–44–0383	6. Sex 1 ☐ M 2/1 F	-) (In yrs. 1a 95	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt Month, Da 02/11/1	911	9. Birth Con Mary	place (State or Foreign intry) 'land
	and *		Usual Residence of Decedent 10a. State 10b. County	1		10c. City	, Town or Lo	cation				-	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	Aarylis f sho	5	MD Calve			Owi	.ngs								1 X Yes 2 ☐ No
	the 28a-	Director	10e. Street and Number					10f. Zip	Code				10g. Citize	en of What Cou	untry?
	hours after death with the Maryland tural; or Items 23s or 28s-f show al Ezonding must be multibud at		2630 Redbud La	ne				20	0736					USA	
	deatl	Funeral	11. Marital Status	12. Was De		ver in U.	S. 13.	Was Deced	ent of His	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	I. Race - Amer Black, White	
٥	after or Ite	Fu /	1 Never Married 2 Ma	ried 1 Tyes	2 (XIN	lo	i	1 🗆 Yes		Specify:			5	Specify: Whi	
	ural',	d by	3 XWidowed 4 □ Divorce	Year or	Dates:										
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7	d within 72 hours after death with the Marylar jiene, then "natural", or litems 23a or 28a-f show the Medical Exandral must be modified at	Completed	Elementary/Secondary (0-12)	College	(1-4or 5-	+)	Homema	_					Own	Home	
0	Hygenthe ant,	Be C	17. Father's Name (First, Middle									e (First, Middle,		umame)	
a	ould be I Mental narked c	To B	Edward Robinso	n						Win	nie	Holland	1		
Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relation					•				al Route Numbe		_	ip Code)
	and 2 eaith m 27 i		Florence Neula	nd / Daug	hter	-				ane,		gs, MD			
ore O	es 1 an of Heal If item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fro	m State	CE	lace of Dispo	natory or o	ther place	9)		Date		ation - City or T	
Ξ	Pages tment of tent: If it		*4 Donation 5 □ Other (Specify)	_	MEGO						02/17/06			
Baltimore,	permit. Pages Department of Importent: If it any injury or o	21. Sign there of Funeral Service Lice 14. Sign there of Funeral Service Lice 14. Fig. 12. Name and Address of Facility L. Kaulinan Funeral Home at Meadowridge Memorial P. 7250 Washington Blvd., Elkridge, MD 21075												orial Park, IN	
			23a. Part1. Enter the disease, of shock, define the failure. Lis	t only one cause or	each lin	10.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a Co	MAL	10	4 T) U-	-5 01	- A	121	HFI	WES,	SDI	SFAJE	Onset and Death
	/Medical Examiner		resulting in death)	Due	o (or as a	a consequ	uence of):								
	Xaiiiiioi	_	Sequentially list conditions, if any, leading to immediate	b	o (or as a	a consequ	uence of):								
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	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	CDue 1	o (or as a	a consequ	uence of):								
/60,	w ~ w	cal		d											
9	ntifica ng ph as th		IC CEMALE.												
ROX	leath certifical attending phy I for use as th	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o		of pregna 2 🔲 Fetal	death 3[]Ectopic pr					23	3d. Date of deli- Month	very Day Year
o.		Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□ Uni		time of de	eath 5	Other (sp	ecify)	-					,
ב.	hat the	Ph	Part II. Other significant condit	ions contributing to	death bu	ut not resu	ulting in the u	nderlying c	ause give	en in Part f	i.	23e. Did t	obacco us	e contribute to	the cause of death?
Records,	law requires that the deas been signed by the a	d by	AORTIL	STENG	51)							1 🗆 🕆	Yes 2 ⊑	HTO 3□Pro	obably 4 Dunknown
Ö	bee bee	Completed				-						24a. Was	an	24b. Were aut	topsy findings available
Ř	9 L 9	omo											rmed?	prior to c death?	ompletion of cause of
Vita	icien: Th certificate rector, pag	a	25. Was case referred to medic	al				 		26. Place	e of Deat	1 ☐ Yes	20 No	1 162	2 140
5	8 5	O B	examiner?	Hospital:] Inpatier	nt 2 🗆	ER/Outpatier	nt 3 🗆 DC	Othe	91: 4 CH	rsing Ho	me 5 Resi	dence 6	Other (Spec	ify)
סר	ding Phy h. After thi funeral c	n: T	27. Manner of Death 1 ☑Natural 5 ☑ Pend	(8.4	e of Injur	y (Year)	28b. Time o Injury	f 2	8c. Injury Work			28d. Describe I			
000	Attending is death. ector: After by the fune.	atic	2 ☐ Accident inves	tigation				М	10	Yes 2 🗌	No				
Division	i Si fi e	Certification:	3 🗆 Suicide 6 🗀 Could deter	minod 200. File		ury - At ho c. <i>(Specif</i> y	ome, farm, str	reet, factor	, office			28f. Location (S City or Tox	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospitel within 24 hours a You the Funeral Completely filled	Medical C		ing Physician: To I Examiner: On the and m		examina									
	o the o the omple	Med	29b. Signature and title of certifi		12			290	. License	number			29d. Date	signed (Month	n, Day, Year)
	⊢ s ⊢ ö		> (1/2 1d	Fleast	12	7			700	163	18		FE	314	2006
	,1		30. Name and address of perso	/		eath (Item	1 23a) (Type,	Print)		00	-			0. 19.	20678.
	7		150H~	7 1 2	IC	5	m).	PA	1~	E	1-16	FDFR	184	(M)	20678.
	Sta		31. Date filed (Month, Day, Yea		ogistra	ar's Signa	ture-	2000	7						
	Registi	al	L FR T	7 2006	A. Mari	and of									

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	St i - i		1. Decedent's Name (First, Middle, Last)							2. Date Mon	of Death	Day	Year	3. Time of Death
	Physici /Medio		Joyce B. Hrycen	ko								RUAR		2006	1015 A M
	Examir	er	4a. Facility Name (If not institution, give	street and nu	mber)			y, Town, or					4c. Coun	ty of Death	
			511 PARK AVENUE		7 4 //-			TIMORI er 1 Year	E CIT		5 D-11	-/ Di-		1 0 5:4	1. (0
	Funeral		5. Social Security Number 6. Se	x]M 21∑7F	7. Age (in yr.	s. last birthday) 2.	Month		Hours	Min.	(Mon	of Birth		Cou	* *
	Director		Usual Residence of Decedent					1			Aug	13,	1953_	New	Jersey
	show		10a. State 10b. County		10c. 0	City, Town or Lo	cation								10d. Inside City Limits
	Mary F	ē	MD			Balti	nore								1∰ Yes 2 □ No
	r 28s	Director	10e. Street and Number				10f. a	ip Code				10	g. Citizen o	f What Cou	ntry?
	1 with	a D	511 Park Avenue	#3B					2120	1				USA	
336	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other then "natural", or Items 23a or 28s-f show imatic event, it a Medical Examinational Landillist at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 ∑ No ive		If Yes, sp	edent of Hi becify Cubar 2 1 No	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes Rican, e	or No- tc.)	ВІ	ace - Ameri lack, White, sity: Wh:	etc.
21212-0030	within 72 ho ene. then "naturi te Medical I	Completed by	15. Decedent's Edi (Specify only highest grad	le completed)	1-4or 5+)	(Give	kind of s	sual Occupa vork done d use retired,	luring mos	t of worki		nk 1	6b. Kind of	Business/Ir	dustry unit
7	giene giene	E O	12	2											
Maryland	be filed tal Hygid d other event, t	Be (17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, A	Aiddle, M	aiden Suma	ате)	
<u>X</u>	ould be Mental narked o	ပ္	Walter Hrycenko			-				na R					
10	a se		19a. Informant's Name/Relationship (7)				-						City or Tow	n, State, Zij	o Code)
ر د	s 1 and 3 if Health Item 27 other tra		Judith Braun/sis	ter	20h	. Place of Dispo		re Dr:	ive L		ood,		08701 0c. Location	- City or T	oun State
baitimore,	00-		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ I	Removal from	State	cemetery, cre	matory o	r other place							
	permit. Peg Department Important: eny Injury c		4 □ Donation 5 13 Other (Specify,		440	tro Cre				2/15			atons		I. Inc.
מ	permit. Peg Department Important: I eny Injury o once.		21. Signature of Funeral S. Nice Licens	1//	rece	or 5	late lti	nore,	omy B MD	2120	⊦ 3	631 1	Falls		Balto, MD
			23a. Part1. Enter the disease, or comp shock, of heart failure. List only of	lications that ne cause on	caused the de each line.	ath. Do not ent	er the m	ode of dying	g, such as	cardiac c	r respira	tory arres	st,		Approximate 2121 Interval Between Onset and Death
,	Physician		Immediate Cause (Final disease or condition	ARTER	RIOSCLE	ROTIC C	ARDI	OVASC	ULAR	DISE	EASE				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):									
	LAdimine		Sequentially list conditions, if any, leading to immediate	b											
	ed Isit	lner	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence or):									
	and and	Examin	that initiated events resulting in death) Last	c	(or as a conse	equence of):									
9/00,	cete be executed physician and the burial-transit	a E													
00		edical		d											
.C. BOX	ie death certifi the attending I hed for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1, □/Yes 2 □ No 9 ☑ Unknown	1 Live	itcome of preg birth 2 □ Fe nant at time of nown	tal death 3	Ectopic Other	pregnancy (specify)			***********			ate of deliv	ery Day Year
L	The law requires that the de ite hes been signed by the a bage 2 should be detached	F	Part II. Other significant conditions co	ntributing to d	leath but not re	esulting in the u	nderlving	cause give	en in Part I		23e	. Did toba	acco use co	ntribute to 1	he cause of death?
S.	signed d be de	d by										1 🗆 Yes	2 🗆 No	3 Pro	pably 4 💢 Unknown
Š	w requir been si should	lete									242	. Was an	241	Were auto	opsy findings available
vital necords,	The lav	Completed										autopsy perform	ed?	prior to co death?	mpletion of cause of
0	100		25. Was case referred to medical						26 Plane	of Death			No	1 🗆 Yes	2 ∐ No
=	ysician: is certific director,	To Be	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3	Othe Othe	×-				/ ice 6⊠O	ther (Speci	SCENE
5	ding Phy h. After thi funeral c		27. Manner of Death		of Injury oth, Day Year)			28c. Injury Work					v injury occi		<i>,,</i> ,
5	ath. r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	170707	iii, Day 16ai)	Injury	М		Yes 2	No					
DIVISION	e Hospital or Attending Physician: 24 hours after death. 8 Funeral Director: Atter this certific etely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place build	e of Injury - At ling, etc. (Spec	home, farm, sti	reet, fact	ory, office				ition (Stre or Town,		nber or Rur	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) Certifying Phyone) Medical Exam	iner: On the b	e best of my k pasis of exami oner stated.	nowledge, deat nation and/or in	h occurre vestigati	ed at the timon, in my op	ne, date an pinion, dea	nd place, ith occurr	and due ed at the	to the cau	use(s) and r	manner as s	stated. o the cause(s)
	To the within 2 To the Complet	M	29b. Signature and title of certifier		200		2	9c. License				29	d. Date sign	ned (Month,	Day, Year)
)	_		Hot. I w	1.11-	rolli	L ws		0	CME			FE	BRUAR	Y 8,	2006
	7		30. Name and address of person who c	ompleted cau	se of death (It	em 23a) (Type,	Print)								
	9		TATRICIA AT	ANING	-45/1	-	11 F	ENN S	TREET	C, BA	LTI	ORE,	MARY	LAND,	21201
	Sta		31. Date filed (Month, Day, Year)		gegistrar's Sig	nature	- 40								
	Registr	वा	CCD 1 7 20	105 16	A	ALL OF	1								

			1 - For State Registrar	State of Marylan		artment of H tificate of L			giene 0 0 6	04671
- 281	Physici	an	1. Decedent's Name (First, Middle, Last)	phuson				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	ath	14 200 4c. County of De	
	Examir	ner	5228 FREDCREST	ROAD		BALTIMO			NIA	
1/5	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. B	irthplace (State or Foreign Country)
1%	Director		74·28·2402	M 2□F 64	Yrs.	WIOTITIS Days	110015 IVII	D9.04.	1941	MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -1 ehc	ţŏ	MD NA	BAI	TIMOR	F.				1 BYes 2 No
	ith the Marylar or 28a-f ehow	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	23a c	Funeral Director	5228 FREDCREST 1	20AD		21229	7		LSA	
	after dea or Iteme	uner		Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - An Black, Wh	nerican Indian, hite, etc.
36	rs afte	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2⁄ No	Specify:		Specify:	3LACK
215-0036	72 hours after death with the Maryland "neturel", or Iteme 23a or 28a-1 ehow ideal Examinational bandified at	ted	15. Decedent's Educ	ation	16a. Dece	ient's Usual Occupa	ition	- 486	16b. Kind of Busines	
21	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,))	orking		~~~
21	filed with Hygiene. other than		12 TH GRADE	NA	Supe	ervisor	10. Mathada N	ame (First, Middle,		STATE UNIV.
and	ould be fi Mental H arked otl atic ever	Be c	17. Father's Name (First, Middle, Last) ENOCH JOHNSON					JACKSON		
Maryland	& BEE	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir				r, City or Town, State	, Zip Code)
Z	1 and 2 Health a am 27 le		EDDIE JOHNSON (BROTHER)		CRAIGMON	T RD.	BALTO- N		494
ore			20a. Method of Disposition 1 ଔBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crer	sition (Name of natory or other place		Date	20c. Location - City of	or Town, State
Baltimor			4 Donation 5 Other (Specify)		. NATU	Name and Address				ND
Ba	permit. Pa Depertmer Important: eny injury		21. Signature of Funeral Service License	Π	_	Name and Address				
# ·	5 7 R		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the deat		51 BAVO. NA er the mode of dying				Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Sudden	Card	iac De	eath			Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	00.		- //		364285
7	Examiner	١.	Sequentially list conditions, b	Ischer	~ , 'C	Cashia	o his	Pathy		20/00
Γ	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S/a / a	A-D	Nea				769 ears
<u></u>	be executed sicien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):	/ //	/			76 years 1,4e time
8760,	ate be ex hysicien he buria		U ⊲	Me 6 is	d O	bes, +	9			1. Le me
9	iffici g pl	Physician/Medical	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
P.O.	that the death cert ed by the ettendin detached for use	iyslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Cirier (specify)				
	res that signed b be deta	by Pt	Part II. Dther significant conditions con	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	w require been sig should b	ed t	Hypert	ributing to death but not resi				1 🗆 Y	es 2 X No 3□	Probably 4 Unknown
မင္ပင	e law re hes be je 2 sho	Completed	Celluli-					24a. Was a	sv prior to	autopsy findings available o completion of cause of
		Con	Hyperl,	Edenia	_			perfor	med? death' 2 No 1 Ye	? es 2 No
of Vital	Physician: The this certificate he ral director, page	Be	25. Was case referred to medical examiner?	ospital:		• 3C DOA Othe		eath (Check only or		
of	Phys or this oral di	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	I SLI DOA	4 Indiani		lence 6 Other (Sp low injury occurred	Decity)
ion	Attending Firdeath.	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		r? Yes 2∐No			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office	-7	28f. Location (S City or Tow	Street and Number or in, State)	Rural Route Number,
Ω	pital o	Ce	29a, Certifier 12 Certifying Phys	islain. To the best of my kno	and other family	Contract of the Act	a data actula	and the to the	name of all and a trade of a	No atable
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examination)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	pinion, death oc	curred at the time, of	date and place, and d	ue to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	- 17		29c. License	number	9	29d. Date signed (Mo	nth, Day, Year)
			After D Fa	Ker		D005	100		4/15/2	20 L
	19		30. Name and address of person who con	tree fear	23a) (Type,	Print)	35	Pikesi	2/15/20 1/11/2, mo	21200
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa		ach.				

Amend item#10e, Type or Printin Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Feb **Physician** 1:43 AM Johnson Geraldine 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 V2 **Funeral** 1 □ M 2 F Hours Months Days Va 52 214-64-2269 Director 8-23-1953 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 10a. State 10b. County N/A Balto Md 1 ☑ Yes 2 ☐ No Director 10e. Street and Number Cole 1612 Cole Street 10f. Zip Code 10g. Citizen of What Country? 21223 Framiner must be 21223 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black "naturel", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Unk other then Elementary/Secondary (0-12) 12th grade College (1-4or 5+) N/A Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fittenent of Health and Mental Hitant: If Item 27 Is marked ott Hilda Wheeler Howard Rather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Charing Cross Road Balto, Md 21229 Donnell Johnson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 ☐ Burial XXCremation 3 ☐ Removal from State 2-6-2006 permit. Page Department of Important: If any Injury or odge. Catonsville, Md Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West all 4300 Wabash Avenue Balto, Md 21215 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertension Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition EMERGENC HYPERTENSIVE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes ZZ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 18591 MD 30. Name and address of person who completed cause of death (Items 23a) (Type, Print) GREENE STREET, BALTIMORE, MARYLAND 2120 SOUTH F. BRAZIE 22 MARC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2006 FEB 1 Registrar

		•	For State Registrar	State of	f Marylan		artmeni rtificate			and M	ental Hy	giene Reg. No.)6 (04673
	Physici /Medic		1. Decedent's Name (First, Middle DORIS	, J	TEN	KIN.					2. Date of De Month 0 2	Day //	Veac 06	3. Time of Death
	Examin		4a. Fecility Name (If not institution	*		antar		Town, or Ltim	Location o	of Death			ity of Death .imo _{re}	
			Irvington Kno 5. Social Security Number		7. Age (In yrs.		If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da			place (State or Foreign
	Funeral Director	- 1	216-20-0538	1□M 2∏F	78		Months	Days	Hours	Min.	July2	4, 1927	Mar	yland
	pu *		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Maryla f sho	ř		imore		ssex								1 Yes X No
	with the hand or 28a-	Funeral Director	10e. Street and Number 1 Eastern Av	ve.			10f. Zip	Code				10g. Citizen o	of What Cour	ntry?
	Jeath The 23	era	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	o- 14. R	ace - Americ	
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene. The state of the	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Giv	3∕∑ No ∕e		1 ☐ Yes 2		Specify:	i, Puerto F	Rcan, etc.)		lack, White, ^{cify:} Whi	
2-0	72 ho natur ilical	eted		nt's Education est grade completed)		16a. Dece	kind of wor	rk done d	luring mos	t of workir	ng	16b. Kind of	Business/In	dustry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		oo NOT us Lster	_		e.		Med:	ical	
	filed v Hygie other t	e Co	12th 17. Father's Name (First, Middle,	Last)		Reg.	L D CCI	- Cu			(First, Middle	, Maiden Sum	ame)	
an	ould be Mental arkad o atic eve	To Be	Carol W. J						Gene	ive	Donne	elly		
Maryland	d 2 should th and Men 7 Is marks traumatic		19a. Informant's Name/Relations Helen Siejac	ship (Type, Pnnt)	e			(Street a	and Numbe	or Rura	Route Numb	er, City or Tow imore		Code)
	tem 27		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crea	sition (Nan	ne of	0)	D	ate	20c. Location	n - City or To	
E O	Pages nent of i ant: If it		1 ☐ Burial 2 ☐ remation 1 ☐ Donation 5 ☐ Other (5		State Ba	ayvie	w Cre	emat	ory	2/1	6/06	Balti	more	MD
Baltimore,	Helen Siejack / niece //24 Gough Street Baltimore MD 20a. Method of Disposition 1 Burial 2 Premation 3 Removal from State Bayview Crematory or other place) 21. Signature of Funeral Service Licensee Bayview Crematory 2/16/06 Baltimore MD 22. Name and Address of Facility Connelly Funeral Homeo 300 MAce Ave. Baltimore MD 21221												eofEssex 21	
	Physician /Medical Examiner	Il Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cha	aused the death ach line. Cor as a consequence of a conse	obstaguence of):	er the mod	-	Pulu	cardiac o	y Du	Seere Desce		Approximate Interval Between Onset and Death
. Box 68	death certifica e ettending ph id for use as th	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ointh 2 ☐ Feta nant at time of d	al death 3	□Ectopic pr □ Other (sp						Date of deliver	Day Year
ds, P	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditi	ions contributing to de	eath but not res	sulting in the u	nderlying c	ause give	en in Part I			tobacco use co Yes 2 □ No		he cause of death? Dably 4 Onknown
æ	The ate h page	Completed									24a. Was auto perfe 1 \(\text{Yes}		b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
Vital	yeician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only			
<u>~</u>	hye this at di	2	1 Yes 2 No	28a. Date		ER/Outpatier 28b. Time o)A	4 NI			how injury occ		(b)
	ng ftei ftei	tlon	1 Natural 5 ☐ Pendi	/ A Am m	th, Day Year)	Injury	М	8c. Injun Work 1 🔲	<br Yes 2□					
Division	To the Hospital or Attending F within 24 hours after death. To tha Funeral Director: After completely filled in by the funer.	Certification;	3 Suicide 6 Could	not be 28e. Place	of Injury - At hing, etc. (Specif	ome, farm, sti fy)	reet, lactor	y, office		2	28f. Location (City or To	(Street and Num wn, State)	mber or Run	al Route Number,
	Hospita 24 hours Funeral	ledical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the I Examiner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due t	stated. o the cause(s)
	o the o tha omple	Mec	29b. Signature and title of certific						number			29d. Date sig		
	- 5 - 5		1 liney	A)	MD		14	74	25		2/14	-(06	
	7		30. Name and address of berson	who completed caus	se of death (Iter	m 23a) (Type,	Print)	6 u	st	- [Balt	na.	ND	2/201
	Sta Registi		31. Date liled (Month, Day, Year FEB 1 7	.95	legistrar's Signa	ature	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:26 P M 02 /Medical Joyce Shaw Jackson 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park #1220 Montgomery 7333 New Hampshire Avenue
5. Social Security Number 6. Sex 7. Age If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours Min. 69 Director 224-50-7026 17 Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Menial Hygiene. Item 27 is marked other than "natural", or itame 23a or 28a-f show other treumatic event, It a Madical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Takoma Park MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 7333 New Hampshire Ave. #1220 20912 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government 2 yrs. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill trient of Health and Mental Hitem 27 is marked others. ပ Sue MAry Bradley Albert Shaw, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5048 6th. Place N.E. Washington, D.C. 20017 Ruth Breckenridge/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State = 5 tment MD Veterans Cem. 02-22-06 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) injury permit.
Departminimporte
importe
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 8 marchall 4217 9th. St. N.W. Washington, D.C. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has **2**√□ No 1 Yes Be 25. Was case referred to medica examiner? funeral director. 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospitel or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. within 24 hours a To the Funerei To the

> State Registrar

P

completely

Medical

(Check only one)

29b. Signature and title of certifier

FEB 1 7 2006

Anastasia T. Gyftopoulos, M.D. 1140 Varnum St. N.E. Suite 040 Wash. D.C. 20017 31. Date filed (Month, Day, Year) Registrar's Signature

29c. License number

1D 000012290

29d. Date signed (Month, Day, Year)

February 15, 2006

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	St	ate of N	larylar	nd / Depa <i>Cei</i>			ealth a D <i>eath</i>		ental Hy	giene	UUD	04(575
	3		1. Decedent's Name (First, Middle	, Last)								2. Date of De	eath Da	y Year	3. Tin	ne of Death
	Physici /Medi		James Donald Jo	hnson								02/12	2/200	6	040	00 м
Esta Contraction	Examir		4a. Facility Name (If not institution	, give street	and numbe	r)				Location	of Death		4c	County of Dea		
		1	818 N. Collingt						timor					N/3	4	
*	Funeral Director		5. Social Security Number 217–40–0754	6. Sex		ige (In yrs. 63	last birthday) Yrs.	Months	n 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. 01/15/	rth ay, Year) 1943	9. Bir Co Mar	thplace (St ountry) Ylanc	ate or Foreign
	pu .		Usual Residence of Decedent 10a. State 10b. County			10c Cit	ty, Town or Lo	cation							10d Insid	de City Limits
	eho	5		7/7											1.00	Yes 2 □ No
	28a-1	ect	Maryland Number	I/A		bal	Ltimore		y o Code				10a Cit	tizen of What C	ounts/2	
	With Po and	5	818 N. Collingt	.OD 722	Onio				205					ted Stat	•	
	ns 23	era	11. Marital Status	· ·	as Deceder	t Ever in U	I.S. 13. V			spanic Ori	gin? (Spe	cify Yes or N		14. Race - Am		ın.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-f ehow enty injury or other traumatic event, the Medical Exercitar must be notified at once.	by Funeral Directo	1 Never Married 2 Marr 3 Widowed 4 Divorced	ed 1	med Forces Yes 2 Yes, Give ear or Dates	? No	1	fYes, spe 1 ☐ Yes	cify Cuba	Specify:	i, Puerto I	Rican, etc.)		Black, Whi		,
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<u>ya</u>	Men Arke	ပ	Newrell Smith							Ruth	Johr	nson				
Maryland	2 sh and ls m		19a. Informant's Name/Relations		•			_						or Town, State,		
2	and ealth m 27		Sr. Pietra - Ca	regiv	er	701 5				ton				re, Mary		
OFF	if ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 Remov	al from Stat	e '	Place of Dispo cemetery, cren	natory or	other place			ate		ocation - City or		
Ë	ment tant: jury		4 ☐ Donation 5 ☐ Other (S	pecify)		Mt.	. Carme							timore,		
Baltimore,	Departimon importent in portent i		21. Signature of Funeral Service	. M	den)	na 40	yid .	nd Addres J. We Ches	s of Facility ber ter	y Funer Stree	al Hom	nes E imor	e, Mary	land	21231
			23a. Part1. Enter the disease or shock, or heart lailure. List	complication	ns that caususe on each	ed the deat line.	th. Do not ent	er the mod	de of dying	g, such as	cardiac o	r respiratory a	arrest,			l Between
	Physician		Immediate Cause (Final disease or condition		SQUA	MAC	is C	ELL	CAR	CINC	MA	OF /	ANU	15	Onset	and Death
25	/Medical Examiner		resulting in death)	(·	Due to (or a											
₹.	Examine	_	Sequentially list conditions,	b	NID	S										
	of sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or a	s a conseq	quence of):									
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387		dicai		d												-
×	death certifi e attending id for use as	Physician/Me	IF FEMALE:	23c. If	yes, outcom	e of pregna	ancy							23d. Date of de	livery	
Box	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		Live birth			Ectopic p Other (s						Month	Day	Year
P.O.	the d y the	ysi	9 Unknown		Unknown				,,							
	requires that the death certif een signed by the attending nould be detached for use as	by Pl	Part II. Other significant condition	ns contribut	ting to death	but not res	sulting in the ur	nderlying	cause give	n in Part I		23e. Did	tobacco	use contribute t	o the cause	e of death?
of Vital Records,	aures n sign	g D										10	Yes 2	12No 3□P	robably	4 Unknown
00	> 0 10	Completed										24a. Was	an	24b. Were a	utopsy lind	ings available
Re	The law cate has be page 2 st	E C										auto	ormed2/	death?		
tal		BeC	25. Was case relerred to medical							26 Place	of Death	1 ☐ Yes (Check only	2 No	1 1 10	2 □ No	
>	S 0 0	To B	examiner? 1 Yes 2 No	Hospit	al: 1 🔲 Inpa	tient 2	ER/Outpatien	t 3 🗆 D	OA Othe					6 Other (Spe	CIN TE	of HOPE
0			27. Manner of Death	28	a. Date of In	jury Jay Vear)	28b. Time of		28c. Injury Work	at		8d. Describe			K	SIDENCE
0	Attending r death.	atio	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	9	(101011111, 2	LL 7 102/7	nijury	М		res 2 🗌	No					
Division	er de	tific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be ned 28	e. Place of I	njury - At h	ome, larm, str	eet, lactor	y, office	-	2	81. Location	Street ar	nd Number or R	ural Route	Number,
	rs aft	Certification:														
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 (Check only one) 1 Medical	g Physician Examiner: C a	t: To the bes On the basis and manner:	of examina of examina stated.	owledge, death ation and/or inv	occurred vestigation	at the time n, in my op	e, date an inion, dea	d place, a th occurre	and due to the	cause(s , date and) and manner a d place, and du	s stated. e to the cau	use(s)
	To t To t	Σ	29b. Signature and title ol certified	7	anin			29	c. License	number			29d. Da	ite signed (Mon	th, Day, Ye	ar)
	1		> sugares	cur	NOL				D 10	6619			FID	nevery	14,	2006
	1		30. Name and address of person	who complet	ted cause of	death (Iter	m 23a) (Type,	Print)		1 -	M	10-	001.	= 2	11 = A	10
			C. VERGARA	- 501	KES	46	140 7	TEAR	IKUN) =	> WW.	THE	IKIV	1= 101	44/./	10.
	Sta Registi		31. Date liled (Month, Day, Year) FEB 1 7	2006	32. Hagis	trar's Signa	ature	SAG.	,						,	ar) 2006 10.

			For	State of Maryla				Mental Hy	/giene	6 016	76
_	la midia i		1 - State Registrar		Cei	rtificate of	Death		Reg. No.	0 040	10
3	Physici	an	Decedent's Name (First, Middle, La					2. Date of D Month	-	3. Time of	
	/Medic	al		MRELL, SR.				Febru	Jary 11	2006 3:5	8/+M
	Examin	er	4a. Facility Name (If not institution, giv	- 11. 1	Anula	11	or Location of Dea	th	46 County	of Death	
- N	Funeral		5. Social Security Number 6. S		Center . last birthday)	If Under 1 Year	dale If Under 24 Hrs	s. 8. Date of Bi	irth 100/	9. Birthplace (State of	or Foreign
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	ehov	7	10a. State 10b. County		ity, Town or Lo					10d. Inside Ci 1 ☐ Yes	
	the N	ecto	MD BALTIM 10e. Street and Number	ore ivi	IDDLE	RIVER			10- 020		2 20110
	with with	Ē	3912 CUTIN SARK	ROAD		10f. Zip Code	'n		10g. Citizen of W		
	death	by Funeral Director	11. Marital Status	12. Was Decedent Ever in I		Was Decedent of I	Hispanic Origin? (Specify Yes or N		- American Indian,	
ဖွ	after or its	Ful	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give	1	if Yes, specify Cub 1 ☐ Yes 2 9 No	oan, Mexican, Puè	rto Rican, etc.)		k, White, etc.	
EC 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow he Mcdical Examiner must be multified at	d b	3 Widowed 4 Divorced	Year or Dates:		10 162 562-140	Specify:		Specify:	BLACK	
0) 10	n 72 l	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	denI's Usual Occu kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Bu	siness/Industry	
6 (withii iene. then	ошь	Elementary/Secondary (0-12)	College (1-4or 5+)		ABORER	7 0)		BETH. S	HEFL	
and 2	Hygid other	Be C	17. Father's Name (First, Middle, Last,			. SOICGE	18. Mother's Na	me (First, Middle	e, Maiden Sumame		
40000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examiner must be multilise at ance.	To B	ERNEST KHIRELL	SR.			ESTELLE	WILKIN	JS		
Mary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (1.	1				ber, City or Town,	State, Zip Code)	
S C	s 1 and 2 f Health a item 27 ie other tra		JEWEL KHIRELL	(MIFE)	3912	CUMIY SA	RK RD.			MD 21220)
干咖	ages 1 int of H t: If ite y or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cren	sition (Name of matory or other pla	100)	Date	20c. Location -	City or Town, State	
大量	permit. Pages 1 ar Department of Hea Important: if item eny injury or othe once.		4 ☐ Donation 5 ☐ Other (Specifical Service Licer		LTO. NA			17.06	BALTIMOR	E, MD	
Ai-	permit. Departn Imports eny inju			ISSE	VA	Name and Address Name and Name an	GREENE FU	NERAL SE	RVICE	a.	
100	dio sy		23a. Part1. En er ne disease, or com	plications that caused the dea	th. Do not ent	er the mode of dvi	NATT PIKE	BALTO.	MD 2122	4 Approximati	19
	Physician		Immediate Cause (Final	one cause on each line.	1 - 0	,	•			Interval Bet Onset and I	ween
	/Medical		disease or condition resulting in death)	a. Emphy Due to (or as a conse	56 ma						
N	Examiner		Sequentially list conditions,	, Tobacco	Abuse						
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٧	executed in end ial-transit	кат	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse							
,09	cate be executed physicien end ; the burial-transit	aiE		Due to (or as a conse	querice (ii),						
68760,	2 4 0	edicai		d							
Box	eath certific attending p for use as	ŊM,	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date	e of delivery	
ů.	ne death the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet]Ectopic pregnanc] Other (specify)	y		Mor		Year
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8		by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.			bute to the cause of d	
oro	v requir been s should	sted						1 🖄	Yes 2∐No	3 Probably 4 □t	Jnknown
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<u> </u>								1 XYes	ormed? d 2 □ No 1.	eath? ✓ Yes 2 No	
Z Z	Physician: The this certificate hiral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	750/0-1-1		hor	ath (Check only			
Ø 6	Attending Physician: r death. octor: After this certifice by the funeral director, i	n: To	27. Manner of Death	28a. Dale of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	30 000	4 🗆 Nursing	T	how injury occurre		
¿ ioi	ttending F death. ctor: After / the funer	atio	1 ♥Natural 5 □ Pending 2 □ Accident investigation		Injury		nk?]Yes 2□No				
$f \in \mathcal{L} \in \mathcal{L}$ Division of Vital Records,	r Atterde	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - Al I	nome, farm, str	eet, factory, office		28f. Location	(Street and Number	ar or Rural Route Num	iber,
H 0	oital o urs af ral D										
The fact	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin	owledge, death ation and/or inv	occurred at the treestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) and mar , date and place, a	ner as stated. nd due to the cause(s	à)
	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
	⊢ s ⊢ ō		165	m.D.		1			1 -	11-06	
	Ω		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type.		0000		0 /	,	
			Dr. Scott Link	9000 Frank	lin So	quare D	rive R	9 Himo	re, mo.	21237	
120 to 12	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1.1.	7		, , , ,		
-	Registr	ar	EER 1 7	2008 Barres	65 B	STATE OF					

			For State Registrar	State of Marylan		rtment of H		Mental H	lygiene Reg. No.	06	04677
	Physici	an	1. Decedent's Name (First, Middle, Last)	D ' D II				2. Date of Month	Day	2000	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give s	Doris B. K treet and number) YERAL HUSP	ing	4b, City, Town, g	r Location of De			unty of Death	Ot as m
	Funeral Director		230-26-9985	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month,	Birth Day, Year) 27–1929	9. Birth	place (State or Foreign ntry) Md
	show)r	Usual Residence of Decedent 10a. State 10b. County Md		/, Town or Loc	cation					10d. Inside City Limits 1XXYes 2 ☐ No
	or 28a-f	Direct	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	
9600	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel; or items 23a or 28a-f show event, the Madical Examinar must be notified at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1	1	Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	Specify:	(Specify Yes or erto Rican, etc.)	Spi	Race - Ameri Black, White, ec <i>ify:</i> Bla	etc. ack
1215-	within 72 ene. than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done OO NOT use retire Omestic	oation during most of w d)	vorking		of Business/In .vate H	·
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 is markad other than " fraumatic event, the Mas	To Be Co	17. Father's Name (First, Middle, Last) Charles King					ame (First, Mic	dde, Maiden Sur	name)	
	ges 1 and 2 should tof Health and Men if Item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Type Darlene Woods -			g Address <i>(Street</i> Evergreet			mber, City or To		p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a important: if item 27 is eny injury or other trac		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	sition (Name of patory or other pla	· 1	Date 6/2006		on · City or T	
Balti	permit. Departm importa eny inju once.		21. Signiture of Funeral Service Lifern e	e Queen D	22.	Name and Addre	ss of Facility 4300 Wat	March eash Ave	F/H We	st	1 21215
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on disease or condition resulting in death)	cations that caused the death e cause on each line.	atic	/	ng, such as card npho acter				Approximate Interval Between Onset and Death
	death certificate be executed x a entiending physician and dofor use as the burial-transit and the control of t	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a)		al B	acter.	em/a			
.O. Box 68	that the death certifics ed by the attending ph detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnanc Other (specify)	у	5371	23d.	Date of deliv Month	rery Day Year
rds, P.	quires that the signed by all be detacted	2	Part II. Other significant conditions con	tnbuting to death but not resu	ulting in the un	derlying cause giv	ren in Part I.		id tobacco use o		the cause of death?
	The law requires that the sate has been signed by the page 2 should be detached.	Completed						24a. V a p	erformed?	4b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
Vital	sician: certific rector.	Be	25. Was case relerred to medical examiner?	ospital:	ER/Outpatien1	2000	05	eath (Check or	lly one)	IO# /G	
ō	Attending Physic death. ector: After this by the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui	y at		esidence 6 L be how injury or		ry)
Division	Dia	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, stre	eet, lactory, office			n (Street and N Town, State)	umber or Run	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in 1	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the til estigation, in my o	me, date and pla opinion, death oc	ce, and due to curred at the tir	the cause(s) and ne, date and pla	d manner as s ce, and due t	stated. to the cause(s)
	vithir To th	M	29b. Signature and title of certifier	dad-		29c. Licens		2_		gned (Month.	
	5		Kevin aut	mpleted cause of death (Item	23а) (Туре, Г	YO 7	Mary	land	Greno	eral ,	Josp Hal
	Sta Regist		31. Date liled (Month, Day, Year) FEB 1 7 2	32. Registrar's Signa	ture	facile					

Part			For State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	2. Date of		3. Time of Death
42 Positive Name (in first entirations; per visited and number) 43 Secul Security Name 44 County of Peach 45 County of Peach 46 County of Peach 47 Age (in yrs. sat birthout) 46 Debug 1 Year 10 Debug 1 Y					KOESTER	Month	Day	/ear
216 - 34 - 1937						of Death	4c. County of	Death
10. State and Number 27.50 CHURCH LANE 28. Manual Forests 100 Location			216-34-1937 XXX 2□F			Min. (Month	Birth Day, Year) 8-1938	Birthplace (State or Foreign Country) MARYLAND
Beautiful and Comments Commen	f ahow led at	lor	10a. State 10b. County	10c. City, Town or Lo		wn		10d. Inside City Limits
Special Property 2-17-2006 CATONSVILLE, MD	a or 28a I be notif	Direc				7	_	
CREMATORY 2-17-2006 CATONSVILLE, MD	il, or items 2 traminer mus	by Funera	11. Marital Status 1 Never Married 12. Was Decedent Exammed Forces? 1 Never Married 2 Married 12. Was Decedent Exammed Forces? 1 X Yes 2 No		Vas Decedent of Hispanic O f Yes, specify Cuban, Mexica	rigin? (Specify Yes or an, Puerto Rican, etc.	r No- 14. Race Black	American Indian, White, etc.
Carbonation	than "nature the Medical E	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	16a. Deced (Give life. L	kind of work done during mo DO NOT use retired)	st of working		
1 Deural 27Coremation 3 Demoval from State Approximate METRO CREMATORY 2-17-2006 CATONSVILLE, MD	c event, I	Be	17. Father's Name (First, Middle, Last)		18. Moth		ddle, Maiden Sumame)
Contained College Cartering Carter	traumati	Ĕ	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Numb	ber or Rural Route Nu	ımbər, City or Town, S	tate, Zip Code)
21. Signature—of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between consense and Death of Conditions are conditions. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Cross and Death of Conditions. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Cross and Death of Conditions. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Cross and Death of Conditions. 25a. Due to (or as a consequence of): 25b. Was deceedent pregnant arrived the death of the conditions. 25a. Base of Conditions. 25b. Was deceedent pregnant arrived time of death of the conditions are contributing to death but not resulting in the underlying cause given in Part I. 25b. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical assumption of cause of death? 25c. Was case referred to medical	ry or other		20a. Method of Disposition 1 ☐ Burial 2又 Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, crem	sition (Name of natory or other place)	Date	20c. Location - C	ity or Town, State
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inclinant Between Onset and Death Approximate Indirect Between Onset and Death Indirect Between Onset Indirect Betw	any inju		21. Signature of Funeral Service Licensee	, ,		ity CVACH/RO	SEDALE FUN	ERAL HOME
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 1 2 3d. Date of delivery Month Day Year 2 2 2 2 2 2 2 2 2	dical niner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as a b. Due to (or as a cause (Disease or injury that initiated events	consequence of):	2			Onset and Death
24a. Was an autopsy findings availa prior to completion of cause of death? 24b. Were autopsy findings availa prior to completion of cause of death? 25c. Vas case referred to medical examiner? 1 Yes 2 No 1	ched for use as the		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	☐Fetal death 3☐				The second secon
autopsy performed to cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death Check only one) 27. Manner of Death Month, Day Year 28b. Time of Injury 28	200	۵	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part			ute to the cause of death? □ Probably 4 □Unknown
26. Place of Death Check only one 26. Place of Death Check only one 26. Place of Death Check only one 27. Manger of Death Natural 28a. Date of Injury Month, Day Year) 28b. Time of Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28d. Describe how injury occurred 28d.	r, page 2 shor					a	utopsy pri erformed2 de	or to completion of cause of ath?
3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	e funeral directo	ToB	examiner? 1 Yes 2 No	28b. Time of	t 3 DOA Other: 4 N 28c. Injury at Work?	lursing Home 5X P	Residence 6 Other	
29a. Certifier (Check orly one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ad in by th	Certific	determined 286, Place of Injur	y - At home, farm, stre (Specify)	eet, factory, office			or Rurat Route Number,
29b. Signature and title of coording 29c. License number DOUS 9552 29d. Date signed (Month, Day, Year) 02/13/0	pletely fills		(Check only 2 Madical Examiner: On the basis of e	examination and/or inv	occurred at the time, date a restigation, in my opinion, de	nd place, and due to ath occurred at the tire	the cause(s) and manner date and place, an	ner as stated. d due to the cause(s)
	woo	Σ	29b. Signature and title of conflier	M.L		9552	29d. Date signed	Month, Day, Year) 02/13/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Kratochvil 6:05 P Mary 13_ 2006 /Medical Feb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Essex Riverview Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 25}F Director 217-30-4944 71 Yrs Oct. 18,1934 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at Director Edgemere 1 ☐ Yes ¾ XNo Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ 21219 United States 8031 Shore Road Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 Is marked other than "naturel", or ite Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 7 Years 18. Mother's Name (First, Middle, Maiden Sumame) Ukn. 17. Father's Name (First, Middle, Last) Be Theresa 2 Lawrence Mancuso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8031 Shore Road Edgemere, Maryland 21219 (Daughter) Olga Kotowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Importent: If ite any injury or ot once. XXBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation, 5 □ Other (Specify) Holy Rosary Cemetery 2/16/2006 Dundalk, Maryland 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with Lucer + duan(Calon Cancer Priysician un-known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 COP 1 Yes 2 No 3 Probably 4 Unknown ted Monie Complet 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy performed? certificate 20 No 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

To the

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and fitle of certifier

7 2006



29d. Date signed (Month, Day, Year)

		•	For State Registrar			d / Depa		of Hea	lth and	Mental Hy		ins i	14680
L.			Decedent's Name (First, Middle, La	st)						2. Date of De. Month	ath		3. Time of Death
* 1	Physicia /Medic		Frances Koso							Februa	ry Da	2006	11:30 PM
	Examin		4a. Facility Name (If not institution, give	e street and numbe	or)		4b. City, To	wn, or Loc	ation of De	ath	4c.	County of Death	1
1			Casey House				Rocky					lontgome	
'n	Funeral Director		192-22-4/9/	ex 7.7 □M 2 1 F	Age (In yrs. 91	last birthday) Yrs.	If Under 1 \ Months D		Jnder 24 H ours M		h y Year) 4, 1	9. Birth Con Pen	nplace (State or Foreign untry) nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f ahow tre Madical Examiner must be notified at	٥	Managara Managara		Pos	10004 1 1 0							1 ☐ Yes 2X No
	28a-	Funeral Director	Maryland Montgon	iery	ROC	kville	10f. Zip Co	ode .			10g. Cit	izen of What Cou	untry?
	3a or	<u> </u>	6111 Montrose Roa	ad			2085	52			U.S	S.A.	
	death ms 2	era	11. Marital Status	12. Was Deceder	nt Ever in U	.S. 13.			nic Origin?	(Specify Yes or No erto Rican, etc.)	-	14. Race - Amer	
9	after or Ite		1 ☐ Never Married 2 ☐ Married	Armed Force			if Yes, specify 1 ☐ Yes 2🛭			eno Hican, etc.)		Black, White	, etc.
3	ral', c	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date:	s:		10 105 22	INO SE	о о спу.			Specify: Ca	ucasian
5 - -	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual C kind of work of DO NOT use i	occupation	g most of v	vorking	16b. K	ind of Business/I	ndustry
2	Athin hen hen	idu	Elementary/Secondary (0-12)	College (1-4c	or 5+)			_			Dot	ail Sale	2.0
2	should be filed within 72 hours after death with the Marylan to Mental Hygiens. The Marylan marked other than "natural", or flems 23a or 28a-f show imatic avant, the Macifiel Examiner must be notified at	S	-11-	1		Sales	s Assoc		Mother's N	lame (First, Middle,			
anc anc	be fi	Be		,								Sumame	
<u> </u>	should nd Men marke umatic	2	Issac Sorens	Tuna Print)		10b Madi	ng Addengs /S			Feinstei		r Tour State 7	in Code)
Maryland 21215-0036	12 sh h and 7 Is m traun		19a. Informant's Name/Relationship (Arlene Schuchner	**	or					Road Ale			
	is 1 and 2 should of Health and Meritem 27 is marke other traumatic		20a. Method of Disposition	Daught			osition (Name matory or othe			Date		ocation - City or	
و	Pages not: If it iny or o		1 X Burial 2 ☐ Cremation 3 ☐						de Fai	o. 8, 200		•	
Baltimore,	artme artme ortani injury		4 Donation 5 Other (Special Signature of Funeral Service Lice		KIII					Jefferson			
Ba	permit. Pages Department of Important: If i any injury or one		Korbert	EEU	an	2,1				an Dr. Ale			-
	Physician /Medical Examiner pnuisi-itansif	cai Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Qause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mye1 Due to (or b. Due to (sr		Astic Squence of):	Syndron		con as care	nac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	t the death certificate by the ettending phy: ached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	_d. 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of c	of death 3[death 5[⊒Ectopic preg □ Other (spec	fy)				23d. Date of deli Month	Day Year
Ś	ires the signed d be det	þ	Part II. Other significant conditions	contributing to death	n but not res	sulting in the u	inderlying cau	se given in	Part I.		obacco (Yes 2		the cause of death? bbably 4 Unknown
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Records,	The lav	Completed								auto	osy ormed?	prior to death?	topsy findings available completion of cause of
ta	iician: Th certificete rector, paç	ø	25. Was case referred to medical					26.	Place of [1 ☐ Yes Death (Check only o	2X No	1 10 165	2 <u>∭</u> No
<u> </u>	Physician: r this certifice ral director, p	To B	examiner? 1 ☐ Yes 2∑ No	Hospital:	atient 2	ER/Outpatie	nt 3 DOA					6 XOther (Spec	(ify) Hospice
Division of Vital	ding Afte fune		27. Manner of Death 1 ⊠Naturaf 5 □ Pending 2 □ Accident investigatio		njury Day Year)	28b. Time of finjury	M 28c	Injury at Work?		28d. Describe			
Divis	or At fler d piract in by	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	280. Place of	Injury - At h etc. (Specia	ome, farm, st fy)	reet, factory, o	ffice		28f. Location (City or To	Street ar wn, State	nd Number or Ru e)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the be miner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred at ivestigation, in	the time, d my opinio	ate and plant, death or	ace, and due to the courred at the time,	cause(s date and) and manner as d place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and Atle of certifier				29c. l	icense nu	mber		29d. Da	te signed (Monti	n, Day, Year)
)			・大木へ		_ ^	ND	D3	35635			Feb	ruary 6	, 2006
	11)		30. Name and address of person who	completed cause of	of death (Iter	n 23a) (Type,	Print)						
	8		Joseph Kaplan (001 Munc	ster	Mill I	Rd. Roc	kvil	le, M	D 20855			
	Sta Registr		31. Date filed (Month Ony (Year) 7	2006 32. R69	strar's Signa	ature	South)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 557M **Physician** 17 2006 /Medical Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) **Funeral** Days Min. Months 12M 20F Hours A29 BUTIMER Director Usual Residence of Decedent 10a. Stale 10b, County 10c. City, Town or Location if Itam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Funeral Director natori 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? SSEIFI 12. Was Decedent Ever in U.S.
Amed Forces?
1 Ø yes 2 D No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify: δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) ACHINE ERAKR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21035 WESTLOSETH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HIGHVIEW 4 ☐ Donation 5 ☐ Other (Specify) tall ston 21. Signatur of Funeral Fervice Licensee 22. Name and Address of Facility VANS FUNERY CHAPE MO1220 FOREST HIL 20015 CM 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Interction cute minutes. /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Dale of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at lime of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🕡 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 R/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury al Work? of or Attending Figure 1 after death. 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifie

2 North Ave. mo. 32. legistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYNCH

2006

D35012

Bel Air, Md. 21014

29d. Dale signed (Month, Dev. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 2006 7:33 Harri /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death bridge Woods Social Security Number If Under 1 Year If Under 24 H/s.
Months Days Hours Min. 6. Sex. 1 S-M 2 ☐ F 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) **Funeral** Birthplace (State or Foreign Country) 20-24 5084 Director PENDSYLVANIE Usual Residence of Decedent 10a. State 10b. County 'natural', or items 23e or 28a-f ehow 10c. City, Town or Location the Medical Exeminer must be notified at 10d. Inside City Limits Md Director 1ay/ors 1 ☐ Yes 2 No 10g. Citizen of What Country? Shore 4.5. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 þ 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) MACHINES 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental SAMUEL ALICE important: If item 27 ie m. any injury or other treum-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21669 BEULAH BAYSHORE 4308 120. TAYLORS ISland MI) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYLIEW Crematory FEB 20, 2006 BACTEMORE MO 22. Name and Address of Facility Bruzo Zinski 21. Signature of Funeral Service Cicensee Home, P.A OLD EASTELD AVE, ESSEX, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (anonome /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed physiclen and the burial-transit Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) Month Day Year OK RS Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor: After this certificete hes been sign the funeral director, page 2 should be Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificele ascular performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No ٩ 1 Tes Hospital: Other: 4 Nursing Home 5 Residence 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 2 Accident 1 Yes 2 No within 24 hours after deatl To the Funerel Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2.13.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Dischmens Lane, Easton, MD 21601 31. Date filed (Month, Day, Year) FEB 1 7 State Registrar

		For	State of Maryla						_	01.683
	1	State Registrar		Ce	rtificate	of Deat			leg. No.	09000
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Examiner		Maryland Ge	1 110001	al	Balt	10000	Citu		n/a	201
Funeral Director		5. Social Security Number 6. 5 218–22–1498	Sex 7. Age Nn yrs	. last birthday) Yrs.	If Under 1 Months	Year If Unc Days Hour	s Min.	Date of Birth (Month, Day 2p. 15	year) 9. 8i	rthplace (State or Forei ountry) Cyland
/land	- 1-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or La	ocation					10d. Inside City Limi
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With the Part of Direct		10e. Street and Number 3047 Strickland	S+		10f. Zip C			1	10g. Citizen of What C USA	ountry?
ifter death v	200	11. Marital Status	12. Was Decedent Ever in I	J.S. 13.			Origin? (Specifican, Puerto Ric	y Yes or No-	14. Race - Am	
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filed within 72 hours after Hygiene. ther than "natural", or ite int, the Medical Examination of the files.	analdui	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)					nost of working		16b. Kind of Business	,
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2 should be filed with and Mental Hygiene is marked other tha aumatic event, the To Re Com		Henry Lloyd Kei	lholtz Sr.			J	ulia			
s 1 and 2 should t Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship Margaret Keilholt		1.0	_				r, City or Town, State, MD 21223	
90= 5		20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Themoval from State	Place of Dispo			Date		20c. Location - City o	
permit. Pag Department Importent: Inny injury o	ŀ	21. Signature of Funeral Service Uce				-			Baltimore (Funeral h	
Dep Per		*Kim Do	hlange	L 3	620 Wi	1kens	Ave. Ba	ltimor	e, MD 2122	23
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ysicie	2		a Cancar)an	14	Clern	<u>u</u>			
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Physician: The ribis certificate har al director, page		25. Was case referred to medical examiner?				26. Pla	ace of Death			3 2010
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To the within 2 To the complet		29b. Signature and title of certified			29c.	License numbe	er	2	29d. Date signed (Mor	nth, Day, Year)
		Lu			0	2504	4		18/16	
5		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	(Few	7 Ref	Ba	19d. Date signed (Mor 2/8/16 UT MD	2111)
State Registrar		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	land.					

				State of Mary	land / Depa		lealth and M	ental Hygi	_	04684
			Decedent's Name (First, Middle, Last)	-				2. Date of Death	1	3. Time of Death
	Physici		JOHN WESLEY KELL	Y				Month O2	10 /2006	IN DO PM
	/Medic Examin		4a. Fecility Name (If not institution, give st			4b. City, Town, o	or Location of Death	04/	4c. County of Dear	
	LAdiiii	EI	LEVINDALE NURSIN			BALTI	MORE		N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bin	hplace (State or Foreign
	Director		212 – 26 – 9095 ¹ \(\forall \)	M 2□F	78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 5-23-19	NOR'	TH CAROLINA
	D .		Usual Residence of Decedent	140	O: T			-		101 1-11 01 11
	aryla shov	_	10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
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	vith th	by Funeral Director	10e. Street and Number			10f. Zip Code	-	10	og. Citizen of What Co	ountry?
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	ltem Item	nue	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever Armed Forces? 1 X Yes 2 No 	In U.S. 13.	If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	rs aft	P. F	3 ♥ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: B	LACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ta Mudical Exartinar that be notified at	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	/Industry
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b	be filled ital Hygik d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	Maiden Sumame)	
<u>la</u>	buld be filled with Mental Hygiene. arked other than atic event, the	ToE	JOHN KELLY				ELIZAB	ETH HOLI	DEN	
Maryland	S D E E		19a. Informant's Name/Relationship (Typ			-			City or Town, State,	
	and salth n 27		MAURICE WARD(NEP	<u>.</u>					MARYLAND :	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cemation 3 ☐ Re	2 amoval from State	Ob. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date 2	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag ment ant: I		'4 □Donation Other (Specify)	Ģ.				The second secon		LLS, MARYLAN
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 tie any injury or other tra 90.59.		21. Signature of Puneral Service License	JONATHAN I	1					E, P.A. RYLAND 21217
	Physician /Medical Examiner		23a. Part / Enter the disease, or complic shoot or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	or respiratory arre	est,	Approximate Interval Between Onset and Death				
760, <	ie be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
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	res that t signed by I be deta	Completed by Ph	Part II. Other significant conditions conf HYPER TENSION		ot resulting in the u	Inderlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?
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of	Phy this ald	lon; To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o	of 28c. Inju	ry at		w injury occurred	cify)
Division	Atter r dea ector by the	Medical Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)			28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	dical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of m er: On the basis of exa and manner stated.	y knowledge, deat imination and/or in	h occurred at the ti evestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	vithin o the ompl	Me	29b. Signature and title of certifier			29c. Licens	se number	25	9d. Date signed (Moni	th, Day, Year)
	- > - 0		Barm H. in	Martin -	7	Ant	63327		2/13/6	6
			30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type,	Print)				
	11/4		GIZAW WOLDEHIND	T,2434	W. Bel	vedere	Ave, Bal	timore	, MD 2	1215
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 7 201	32. Registrar's	Signature					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State #11 RAMETIC TTem #1 Per FH G852 2/1 / Retificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician LUBOVSK 5:09 IRA FEERVARY 12, 2006 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NOCTAWEST HOSPITAL BALTIMORE PAUPALLSTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year) JAN. 26, 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months D.C. 70 Director 247-50-2041 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. shirt if item 27 is marked other then "natural", or items 23a or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE #219 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. YYes 2 ☐ No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-College (1-4or 5+) SALESMAN INSTALLMENT 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **LOBOVSKY** VOGEL ETHEL BENJAMIN Lubovsky 19a. Informant's Name/Relationship (Type, Print)
JUDITH LUBOVSKY / WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 7 SLADE AVENUE #219 - BALTIMORE, MD 21208 WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ö Depertment of importent: if eny injury or once. BETH EL MEMORIAL PARK 02/16/2006 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DISEASE ATMEROSCLERITIL CARDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sacuentially list con flicing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, nding physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Be Completed by page 2 should be 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D4349

31. Date filed (Month, Day, Year) State Registrar

MIGHTEL

ROTHKIN 32. Registrar's Signature

5401 OUD LOVRT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

DHMH 17 Rev 1/2001

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		for State Registrar	State o	f Marylar		artment <i>tificate</i>				lental Hyg	iene ag. No.	06	04687	
51		1. Decedent's Name (First, Middle, L	ast)					-		2. Date of Dea Month	th Day	Year	3. Time of Deat	h
Physici /Medic		Margaret Dean	Lemke							Februar				1 ^M
Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, 7	own, or	Location of	of Death		4c. C	ounty of Dea	ath	
		Hebrew Home					kvi]					ntgome		
Funeral			Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey	Year)	(rthplace (State or Fore Country)	əign
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and and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Lim	nits
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or ite	E	1 Never Married 2 Married		2 🕅 No		rγes,spec 1⊡ Yes 2				Mican, etc.)		Black, Wh	ite, etc.	
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yland ould be fill Mental Hy arked oth	Be	17. Father's Name (First, Middle, La								•		umame)		
ylc ould Mer Marke narke	၉	Charles Gilbert I			1	÷=				Fritsc		T 0	7.0.1	
Darkimore, Maryland permit. Pages 1 and 2 should be fil Department of Health and Mental th Important: If item 27 is marked ott any injury or other traumatic even		19a. Informant's Name/Relationship								al Route Numbe				
e, land land land land land land land land		Alan E. Lemke (20a. Method of Disposition	Son)	20b.			11.7			Date			MD 20904 or Town, State	
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tir Pa tmen tmet tant:		`4 □Donation 5 □Other (Spec		Ber	rmuda N					17-06		ster,	VA	
Sattimor permit. Pages Department of important: If it any injury or o		21. Signature of Funeral Service Lic	ensee							eral Ho				-
46244		23a. Part1. Enter the disease, or co	um	ene						lonial		nts. V	A 23834 Approximate	
		shock, or heart failure. List on	ly one cause on	each line.	tri. Do not ent	er the mode	e or ayıng	j, such as	Carciac	or respiratory arr	esi,		Interval Between Onset and Death	1
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Con	gestive	Heart	Failu	ıre							
/Medical Examiner		rosarting in dodairy		(or as a consec										
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death cer death cer e attendir	Physician/M	in the past 12 months?		birth 2 Fet nant at time of		□Ectopic pre □ Other (spe						Month	Day Year	
the the character of th	iysi	1 □ Yes 2 🏹 No 9 □ Unknown	9□ Unki	nown										
F ta ta	by Pi	Part II. Other significant conditions	s contributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part	1.	23e. Did to	bacco us	e contribute	to the cause of death	?
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99 =	o B	examiner?	Hospital:	Inpatient 2	TER/Outpaties	nt 3□ DO	Othe			me 5 Resid		□Other (Sr	necify)	
_ = =		27. Manner of Death	28a. Date	of Injury	28b. Time o		8c. Injury Work		aroming	28d. Describe h				
on on ading Father a funera	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Yeer)	Injury	м		ດ? Yes 2. □]No					
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DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	4 Homicide	buile	ding, etc. (Spec	(Y)					City or Tow	, JIAI(A)			
ospiti hours inera y fille			Physician: To th											
ne Ho n 24 ne Fu	Medical	(Check only 2 Medical E)		basis of examin nner stated.	ation and/or in	ivestigation,	, in my op	oinion, dea	atn occui	red at the time,	uate and	piace, and d	ue to the cause(s)	
To th within To th	ž	29b. Signature and title of certifier	V	nx.	1	290	. License	number			29d. Date	signed (Mo	nth, Day, Year)	
		296. Signature and title of certifier Andere	leen	Versi	UT	D	0036	5716			Febr	uary 1	3, 2006	
σ_i		30. Name and address of person w	no completed cau	use ol death (Ite	m 23a) (Type,	Print)								
10		Andrew Kundrat,	M.D.	6121	Montro	se Ro	l., F	Rockv	ille	, MD 20	852			
St	ate	31. Date filed (Month, Day, Year)		Registrar's Sign		-								
Regist	rar	FFR 1 7	2006	market .	# 4									

	•	1 - State Registrar			n waryte		ertificate		th and M		Reg. No.	2006	0468
icia dic	-	Decedent's Name	(First, Middle	o, Last) Jo se j	ph Edv	ward :	Long, S	r.		2. Date of De Month Februa	Day	Year 4. 2006	3. Time of Death 9:35 P
in		4a. Facility Name (/f	not institution	n, give street and nu	mber)		4b. City, T	own, or Loca	tion of Death			County of Dea	ith
		18 Barba	ara Lar	ne				dgemēr				Balt	imore
il r		5. Social Security Nu 229-36-3	950	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yr	rs. last birthd Yrs	Months		nder 24 Hrs. Purs Min.	8. Date of Bi (Month, D Aug. 1	ay, Year)	00	thplace (State or Forei ountry) rginia
	_	Usual Residence of 10a. State	10b. County		10c. (City, Town or	r Location		D 3				10d. Inside City Limi
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1	2	12 Year					Electri				1	cal Uni	ion#24
	To Be	17. Father's Name (W. Lor	•					Mother's Name Della Ke		e, Maiden .	Sumame)	
1		19a. Informant's Na	me/Relations	hip (Type, Print)		19b. M	ailing Address (Street and N	umber or Rura	l Route Numb	er, City or	Town, State,	Zip Code)
		Mr. Josep	·	Long, Jr.	(Son)		8 Barba sposition (Name		_	emere,		land 2	21219
		·	Cremation	3 □Removal from pecify)	State	cemetery, o	p Servi	er place)					Maryland
		21. Signature of Fur	neral Service	Licensee	0		22. Name and	Address of Ruck E	acility uneral	Home of	of Du	ndalk.	Inc.
		HA	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222										
		23a. Part1. Enter th	a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
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		resulting in death)	ı	a. Due o	or as a cons	equence of):			Morra				20 month
r	76	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	e l	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury											
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-	-	27. Manner of Death		28a. Date		28b. Time				8d. Describe			eny)
1	catlon	1 Anatural 2 ☐ Accident	5 Pendir investi	gation (Mor	oth, Day Year)	Injui	М	c. Injury at Work? 1 \(\text{Yes}	2 🗆 No				
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	Medical	29a. Certifier (Check only one)	1反 Certifyin 2回 Madical	ng Physician: To th Examinar: On the t and man	e best of my k pasis of exami nner stated.	nowledge, de ination and/o	eath occurred a r investigation, i	t the time, da n my opinior	ite and place, a , death occurre	and due to the ad at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	ž	29b. Signature and	1 /	easail	am	, M.	_	License nun				signed (Mont	th, Day, Year)
		30. Name and address	ess of person										
Sta		31. Date filed (Mont	h, Day, Year)	32.1	Registrar's Sig	nature	frede			·			
			LEDI	7 2006	10 Strong	13	130346						

Amend item 1 per doc 8522-17-06 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Adolfina Larrinaga 3. Time of Death Dav **Physician** Vear 0510 0 M /Medical 31 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 9: Birthplace (State or Foreign Country) Cuba 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖾 F 74 595-49-3279 Director 10-27-1931 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "natural, or items 23a or 28a-f show traumatic event, the Madical Extendiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5517 Alderbrook Ct. 20851 death by Funeral Cuba 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Never Married 2 Married Baltimore, Maryland 21215-0036 MXYes 2 No Specify: Cuban Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Manuel Lopez Severina Larrinaga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manuel Cruz/son 5517 Alderbrook Ct. Rockville MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ter
any injury or oth 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Chesapeake Crematory 02-02-2006 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ecopon) /Medical Due to (or as a consequence of): **Examiner** pertensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, to leade or injury that initiated events for as a consequence of): Examiner certificate be executed signed by the attending physicien and the detached for use as the burial-transit 019 resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 → No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Buen.s Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ⊋No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospitel or Attending Pt within 24 hours after death.
To the Funerel Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DED5 7884 1/31/2006 53. 1 s//w hows During 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

			1 - State Registrar	State of Maryland	/ Department <i>Certificate</i>		lental Hygie	Z U U b	04690
			1. Decedent's Name (First, Middle, Las	1			2. Date of Death		3. Time of Death
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	Examir	er	4a. Facility Name (If not institution, give	street and number)	4b. City, To	wn, or Location of Death		4d. County of Death	1
			5. Social Security Number 6. S	114 Medical	t birthday) If Under 1	HOT MORE		0.014	
	Funeral Director			ex 7. Age (In yrs. last		Days Hours Min.	8. Date of Birth (Month, Day, Ye	par) 9. Birth	nplace (State or Foreign untry)
			Usual Residence of Decedent	70			7/21/20	reni	sylvania.
	rylan		10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
	Ba-f s	cto	MD BALITI	noke	BALITA	ORE			1 ☐ Yes 2 No
	with th	Director	10e. Street and Number	1. 01	10f. Zip C	ode 2/22/	10g.	Citizen of What Cor	untry?
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	fler d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	If Yes, specify	t of Hispanic Origin? (Sp. Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
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ary	2 should and Men Is marke sumatic	-	19a. Informant's N-me/Relationship (Type, Print)	19b. Mailing Address (S	itreet and Number or Run	al Route Number, Ci	ity or Town, State, 2	Tip Code)
	iges 1 and 2 should be filed within 72 hours after deeth with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, it a Marical Examiner must be netitied as		Barbasa Mery	in	10 michae	la Ct. B	HLTIMORI	E MD &	21234
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	e of Disposition (Name etery, crematory or other	of or place)	Date 200	. Location - City or	Town, State
Ë	E try		`4 □ Donation 5 □ Other (Specify	Mailioval Itolii State	S Funcial Char		7/06 F	crest Hill	MO.
3ail	Departi Departi Importi any Inju		21. Signature of Funeral Service Licen	See	22. Name and	Address of Facility		ORE, MO:	
	40360		220 Part Sptor the disease or com	lipotics that assumed the death.		-uneral (na		HAKFORD,	Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		or dying, such as cardiac o	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen	NENTIA				
	Examiner			200 10 (0) 03 0 0013040611	100 017.				
	P #	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Classes or ir jury that initiated events	Due to (or as a consequen	ice of):				
	ecute and I-trans	Examine	that initiated events resulting in death) Last	c	age of				
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687	ificate g phys as the	edical		. d					
Вох	death certific e attending p id for use as	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of deli	ivery
	0 60	Physician/M	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown				Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown						
S	es op pe	þ	Part II. Other significant conditions of the Chronic on the t		ng in the underlying cau W/MUNA	A	4		the cause of death?
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Re	The law ate has b page 2 sh	ompleted	hy per TENSI	J / 1			24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
		e Co	25. Was case referred to medical			DC Blood of Doct	1 □ Yes 2 □		25 No
ξ	S S D	0 0	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ DOA	Other	n <i>(Check only one)</i> me 5 ☐ Residence	e 6 Other (Spec	cify)
0 U		T:uc	27. Manner of Death 1 Natural 5 Pending				28d. Describe how		
Sio	Attending r death. sctor: After oy the fune	catle	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	l or Atten after deat Director: I in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, o	ffice	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
_	Hospital or 24 hours afte Funeral Dire stely filled in I	O	29a. Certifier 1 1 Certifying Ph	ysician: To the best of my knowle	odge, death assured at	the time, data and place	and due to the caus	co(s) and manner as	stated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	and/or investigation, in	my opinion, death occur	ed at the time, date	and place, and due	to the cause(s)
	within 2. To the I complete	Me	29b. Signature and title of certifier	_	_	icense number		Date signed (Month	h, Day, Year)
) ,	2		Moun C	m mo	J	135102	Fc	bruch	115 2006
7			30. Name and address of person who	- MA	3a) (Type, Print)	W. V. Ball	100411/4 10	10 mg / 1	- 71211
			31. Date filed (Month, Day, Year)	- 100 WEST	401h 311	LLV SHY	TANOLE A	MINAY LAN	7 41411
	Sta Registi		FEB 1 7 201	3. Registrar's Signature	parte				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Manson Year **Physician** 20 12:00 AM 1.2 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BULTO MIL ひてして WINDSOR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-74-0765 10M 210F Yrs 50 JAV1 25, 1956 BALTO MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examinar must be notified at 1 Yes 2 No Directo BALTIMOVE WINDSOV MIL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA or items 23s 21240 OFLC Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after in Hygiene.

Other then "neturef", or iter ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ģ 3 Widowed 4 Divorced BUK Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 TU GRADE LYRS HEVALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I int: If Itam 27 to marked of P WHILLACE MItchell well-HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21239 SELKERK My DYRUM NAUSO posso ~ 70 Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If its
any injury or ot
once. 1 ☐ Burial 2 **©**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02 Greenmount 06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 24 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Multi Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death). Due to (or as a consequence of): Examine been signed by the attending physicien and should be deteched for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes al director, page 2 autopsy performed? 1 Yes 2 No 1 Yes 2€ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation М 1 Tes 2 No 2 Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/15/2006 D0042593 Bacho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bult MD 21201 22 South Greene St Beidins Ashrob 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year Physician Mahala, Sr. Johnny 6:23 PM February 11,2006 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Harbor Hospital N/A Baltimore City If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1X M 2□ F 218-44-9610 Jan. 19,1948 Director 58 Virginia Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "nature!" or the taumantic event any injury or other traumantic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo Baltimore City N/A Maryland 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 21205 United States 935 Quantril Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 Years College (1-4or 5+) Trucking Industry Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Ruth Watson Walter Martin Mahala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John M. Mahala, Jr. (Son) Bessemer Ave. Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 2/17/2006 21. Si oture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoely, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical (ancer **Examiner** Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 20 No 1 ☐ Yes 2 ☑ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 24 hours after death.

Funeral Director: After this letaly filled in by the funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 🗹 Natural 1∏Yes 2∏No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examility: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funel completaly fil 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 252749 JAYAM HIRPARA 3 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Smyh 31. Date filed (Month, Day, Year)

FEB 1 7 2006

Street

32 Registrer's Signature

Je ALVEN

Bartimore

Black Indelible Ink. Ensure All Copies Are Legible.
Amend 1 tem 8 per fn 8852 2-22-06 vt
and 1 Department of Health and Mental Hygiene
29d per doc 8852 2-22-06 vt
Certificate of Death Please Type or Print in Black Indelible Ink.
Amend item#2,perMD,0852,2017/06 TIT Amend item#8 Amend Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 8 **Physician** Alfred Charles McQuade, Jr. 3:30 P M February 5,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Co. Edgewood 1307 Charlestown Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**∑**M 2□F 36 Yrs Director 218-11-8515 June 27,1969 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Modical Examinat most be notified at 1 ☐ Yes 2 X No Edgewood Harford Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21040 death 1307 Charlestown Drive Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within inner of Health and Mental Hygiene. ant: If Item 27 Is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) NSA 1 Year Systems Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephanie Orlick Alfred C. McQuade, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary T. McQuade (Wife) 92 Kinship Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o 1 Burial 2XXCremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 2/10/2006 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Maryland 21222 21. Signature of Funeral Service Licensee Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyper Thusive you to (or as a consequence of): Physician ARTERIOSCHEADTIC CARDIO VIBO YUK /Medical Examiner E aquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate After this certification, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? nner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funs completely fi Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh MQ DME 7018 HOLABIRO AVE BERNARD BALTO Vid 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylar	nd / Department of Certificate		lental Hygie	4000	04694
R To	Physici		1. Decedent's Name (First, Middle, Last	e Muer	S SR		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir Funeral Director		5. Social Security Number 6. Se 213-26-5045	street and number) 2 n er al Ho; (M 2 F 7. Age (In yrs.	Dital Bollet birthday) If Under 1	rear If Under 24 Hrs. Nays Hours Min.	8. Date of Birth	4c. County of Deat World 9. Birt 1931 Ba	h STER. hplace (State or Foreign unity), IHMORO, MO
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County RALDA	10c. Cit	y, Town or Location PALTIM	ORE		·	10d. Inside City Limits 1 ☐ Yes 2 No
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f ehow eumatic event, the Mydical Examinar must be notilled at	by Funeral Director	10e. Street and Number 3505 Linbel 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 □ Yes 21 No If Yes, Give Year or Dates:	10f. Zip Co	ode 21334 It of Hispanic Origin? (Sp. Cuban, Mexican, Puerto		Citizen of What Co USA 14. Race - Ame Black, White	rican Indian,
121215-0036	e filed within 72 hours at Hygiene. other then "natural; vent, the Mydical Exi	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Decedent's Usual C (Give kind of work of life. DO NOT use of	done during most of work retired)	ing N	b. Kind of Business/	Industry V.A.
Maryland	should be filed and Mental Hyg marked othe imatic event,	To Be	17. Father's Name (First, Middle, Last)	ers		Viola	e (First, Middle, Mai	Klin.	
Baltimore, Ma	Pages 1 and nent of Health sut: If item 27 art: If item 27 art or other to		20a. Method of Disposition 1 Burial 2 Of Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	19b. Mailing Address (S 3505 L) Place of Disposition (Name isometery, crematory or othe NS Fugneral CNO	nbelle Te pel-Bollin.	riace, E	C. Location - City or	e NO 21234
Bai	÷		21. Signature of Funeral Service Licens 23a. Part I. Enter the disease, of compishock, or heart failure. List only o	· Zaviothy	EVHOSFA	Moress of Facility A	HOLE WOLE HOLE, 5800 or respiratory arrest	HARFORE	2 3 4) (20) Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner physician and physician and the prial-transit	ilcal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or a) (o		20100x			5 d74
4 14/200.	death certific e attending p id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 Ectopic pregr			23d. Date of deli Month	ivery Day Year
1931 - 1340 rds, P	w requires that been signed b should be deta		Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying caus	se given in Part I.			the cause of death?
E. 9/23/1931 134 ital Records, 1	The la	Completed	OS Western the project				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 ☐ No
- 5045	Ø	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury M	Other: 4 Nursing Ho	h (Check only one) me 5 Residenc 28d. Describe how		Sify)
- 01:-	al or Attend s after death al Director: / ad in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, of	ffice	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Myers, 213-	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred at the tion and/or investigation, in	he time, date and place, my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2/	29c. Li	cense number 44283	29d.	Date signed (Month	n,[Day, Year)
-	10		30. Name and address of person who co	empleted cause of death (Item 973		9 Drive	Bert	1 , m	D
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 20	32 Registrar's Signa	ture deside				

DHMH 17 Rev 1/2001

Registrar

FEBRUARY 12, 2006

VIRGINIA MALONEY

				State of Marylan				•	_	
			State Registrer			tificate of			g. No.	6 0469
	Physicia	n	Decedent's Name (First, Middle, Las					Date of Death Month	Day Year	3. Time of Death
T	/Medica	al	Mary Mar 4a. Facility Name (If not institution, give	ning street and number)		4b. City, Town, o	or Location of Death	February	16, 2006 4c. County of Dea	
	LAAIIIII	-1	Gilchrist Center f	or Hospice		Tows	on		Baltimo	
	Funeral		5. Social Security Number 6. Se	TM 2□F	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 922 Mar	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	X 8	3			oury 10,	1322 Mar	yıand
1	arylan ehow	_	10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits 1 Tyes 2 No
10 4 h	the M	ecto	Maryland Baltimore 10e. Street and Number	E	ssex	10f. Zip Code		10	g. Citizen of What C	X
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or iteme 23e or 28e-f ehow event, the Medical Examinar must be motified at	Funeral Director	_	. 120			21221			USA
4	r deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	rs afte	by F	1 Never Married 2 Married Widowed 4 Divorced	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:	1	□Yes 2XNo	Specify:		Specify:	White
21215-0036	72 hours after neturel; or its	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup	pation during most of worki	100	6b. Kind of Business	
12 H	within and then a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	_	_		9		
2 5 G	filed v Hygie other t		17. Father's Name (First, Middle, Last)		тете	ephone Op	18. Mother's Name	(First, Middle, M	Communic	ations
'an	should be nd Mental marked c	To Be	Charles H	lynes			Lucile	Fidd	is	
106 Maryland	0, 0		19a. Informant's Name/Relationship (7 JoAnne Nadeau (d	iype, Print) laughter)			and Number or Rura			
-	f Heelt f Heelt ftem 2 other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other pla		-	Oc. Location - City or	
) E	Pages nent of ant: If I		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Quantion 5 ☐ Other (Specify	Removal from State	-		ery 2/18/	2006 в	altimore 1	Maryland
∠// € Baltimore,	permit. Pages 1 end Depertment of Heelth Importent: If Item 27 eny Injury or other tr once.		21. Signature of Fundant Service Licens	500	100	. Name and Addre	DI		i Funeral	
	40200	-	23a. P. rt1. Elter the disease, or comp shock of heart failure. List only of	lications that caused the deat	h. Do not ente	407 Old	Eastern A	venue Es	sex Maryla	and 21221
	Physician		shock of heart failure. List only of Immediate Cause (Final disease condition	0	50.0	/		,	.,	Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or as a conseq	-	137				years
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289	physic the b	dicai		d						
Box 6	death certifica le attending ph ed for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of de	livery
. B	o death	sicia	in the past 12 pronths? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	у		Month	Day Year
Ja.	het the od by th	Phy	9 ☐ Unknovin \ Part II. Other significant conditions co		ulting in the ur	dorhing cauca an	roe in Part I	23a Did taha	acco uso contributo t	o the cause of death?
≷ sp	The law requires that tie has been signed be age 2 should be deta	Completed by Physician/Medi	Dementin	with bothing to doctor but not not	aking in the di	idenying cause gi	TOTAL F GILL.	1 🗆 Yes	1/	robably 4 DUnknown
	aw rec is beer 2 shou	piete	,					24a. Was an	24b. Were a	utopsy findings available
ANN/W al Records,	The I	E O						autopsy performe	ad? death?	completion of cause of 2 No
Vita	Physician: this certifical	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Death			
\$	Physer this eral on	10	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	T 3 DOA	4 Nursing Hor	ne 5 ☐ Residen 28d. Describe hov		icity) (22) 4
FRY vision of	anding vath. or: After he funer	atio	Natural 5 Pending investigation		Injury		rk? Yes 2 □No			
2 A R	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
8			29a. Certifier Certifying Phy	vsicien: To the best of my kno iner: On the basis of examina	wledge, death	occurred at the tr	me, date and place, a	and due to the cau	use(s) and manner a	s stated.
	the H thin 24 the F mplete	Medical	29b. Signature and title of certifier	and manner stated.						
	T W S	-	A A A	Lun		29c Licens			d. Date signed (Mon.	
	9		Name and address of person who d	completed cause of death (Item	п 23а) (Туре,	Print) (A)	U ()	110	0000	16 2006 one MD 21204
			AARO.	001	(W()	4001	V. Wor	les st	BRAM	ore MD 21204
	Stat Registra		31. Date Nied (Month, Day, Year) FFR 1 7 21	32. Registrar's Signa	Maria Maria	side!				

				State of Ma						•	•	42 1 4 4 4 4
			1 - For State Registrar			Cei	rtificat	e of D	eath	Ro	g. No.	04697
П	Physicia	an	1. Decedent's Name (First, Middle, I							2. Date of Deat Month	Day Yea	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g	MIKALASK	- 1		4h City	Town orlo	ocation of Death	FEB	13 2006 4c. County of De	
	Examin	er	TOWARD COUN		M				MBIA		145W A	
	Funeral		Social Security Number 6.		e (In yrs. I	ast birthday)	If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		578-05-0571 Usual Residence of Decedent	1 ⊠ M 2□F	90	Yrs.	W G I K I I			March 1	3,1915 Wa	shington, DC
	yland Iow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Maria-fst	ctor	Maryland Howard	1	E	llicot	t Ci	ty				1 Tes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at once.	Director	10e. Street and Number 3202 Hearthstone	Pood			10f. Zip		1042	11	0g. Citizen of What U.S.A.	Country?
	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13, V	Was Deced			ecify Yes or No- Rican, etc.)		nerican Indian,
စ	after o	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X;Yes 2 ☐ ! If Yes, Give			fYes, speo 1 ☐ Yes		Mexican, Puerto Specify:	Rican, etc.)	Black, Wi	
8	hours ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:	WWII			-			Specify:	White
7	in 72 in "net	Completed	15. Decedent's (Specify only highest of	grade completed)	- 1	16a. Deced (Give life. I	dent's Usua kind of wo DO NOT us	al Occupation In done during reserved (1975)	on ing most of work	ing	16b. Kind of Busines	ss/Industry
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nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, La	st)				18			Maiden Sumame)	
3	hould d Men narke natic	To	Ivan Mikalaski 19a. Informant's Name/Relationship	(Tuna Print)		10h Mailie	a Addraga	/Stroot and		y Erdman	City or Town, State	Tin Code)
	nd 2 suith an 27 is i		Janis Caracofe				-					ryland 21042
Jre,	of Head		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nar	ne of			20c. Location - City	
Ē	Page ment c ant: If		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Special		Cem	ingtor etery				2000	rlington,	Virginia
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Lik	10		22 V	Name an	d Address	eral Hom	e, Inc.		
	40 2 W G		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused								ryland 21045
E	Physician		Immediate Cause (Final	ly one cause on each lin		Jo		, ,				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as								CONYS
В	Examiner		Sequentially list conditions,	b. Isans			2174	Ś				10 DAYS
7	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):						
/ ດ	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ience of):						
3760,		icai	,	d								
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ncv					2015	
Вох	that the death certific ed by the attending p detached for use as	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 4 □ Pregnant at	2 Fetal	death 3	Ectopic pr				23d. Date of o	Day Year
Ö.	t the d by the tached	hysi	9 Unknown	9□ Unknown								_
S, P	signed be det	by P	Part II. Other significant conditions	contributing to death b	ut not resu	Ilting in the u	nderlying c	ause given	in Part I.			to the cause of death?
Records,	w require been si should b	eted	PNEUMONIA	C								Probably 4 ☐Unknown
Rec	ne law has b	mpl	MUTO ROWAL	MILURO						24a. Was a autops perform	y prior t ned? death	autopsy findings available completion of cause of
Vital		O	25. Was case referred to medical					2	6 Place of Deat	1 Yes 2		es 2 No
Ž	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 3 No	Hospital:	ent 2 🗆 1	ER/Outpatier	nt 3 🗆 DC				ence 6 Other (S)	pecify)
o uc	ing After une		27. Manner of Death 1	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Injury at Work?	1		w injury occurred	
Division of	deal deal ctor: / the	licat	2 Accident investigat 3 Suicide 6 Could not	be as Place of Ini	urv - At ho	me, farm, str	M eet factors		s 2 No	28f. Location (St.	reet and Number or	Rural Route Number,
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	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my know	wledge, death	n occurred	at the time,	date and place,	and due to the ca	ause(s) and manner	as stated.
	thin 2, the final the fina	Med	one) 29b. Signature and title of certifier	and manner sta	ated.			. License n			9d. Date signed (Mo	
)	5 7 ¥ 5 8		Daroll	Jaym					5974			, 2006
	13+1		30. Name and address of person wh	o completed cause of d	leath (Item	23a) (Type,	Drien			PKWY		a mo 21074
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 2	32 Registr								
1.50			LEDI	OUU.	- Jan 1	1						

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Amend item#15,16a b,17,18,19a b,20a c,20a per FH, 1853, 37176 TT

State of Maryland / Department of Health and Mental Hygiene 0 6 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year FER RTH 2:24 AM 2006 Carolyn Messer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Bay, Year)

Months | Days | Hours | Min. | Apr 18, 1942 SAINT HUNES HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F unk Director 63 Yrs. 236-64-1303 Usual Residence of Decedent r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No MD Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code rei', or iteme 23a or Examiner must be r 10 N. Rock Glen Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give ☒ Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 X Widowed 4 ☐ Divorced er than "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk ntal Hygiene. ed other than event. the M Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Donestic 10th unk Baltimore, Maryland unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk th and Mental H 7 is marked of treumatic ever Irene Douglas John Leslie 19a. Informant's Name/Relationship (Type, Print) Bill Martin/ Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7172 Peace Ct. Columbia, MD 21045 permit. Pages 1 end 2 s
Department of Health ar
Important: If item 27 is
any njury or other treu St. Agnes Hospital 900 S. Caton Avenue baltimore, MD 21229 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 2/24/2006 4 □Donation 5 ▼ Other (Specify) in state 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Wylie Funeral Services 927 Liberty M. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21133 man Part1. Inter the disease, or complications that ca shock, or heart failure. List/only one cause on ea sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL **Physician** FAILURE HOURS /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions. sequentally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of). Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES HELLITUS 1 Yes 2 No 3 Probably 4 Onknown Completed PERIPHERAL VASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No After thi. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number P 1 9 9 2 4 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6. chatuenede 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARIMA CHATURULD I; S. CATON AVENUE, BALTIMORE, MD, 21229

State Registrar 31. Date filed (MTEBY, Year 2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene of the Print Index of the Pr

•			For State Registrar	State of Ma	•	•	nent of He cate of D			giene	04699
	Dhysisi	an	Decedent's Name (First, Middle, L.)	ast)					2. Date of De Month	ath	3. Time of Death
	Physici /Medio	cal	Pamela	MATTA		46	City Town or L	ocation of Death	2	5 Z 0 0	C 9: 40 PM
	Examin	ier	John Hop Kon	im i i	Care Cent	1	3 Attim	See Co	4	4c. County of	Death
	Funeral			Sex 7. Ag	e (In yrs. last birth	Mor		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	iy, Year)	. Birthplace (State or Foreign Country)
	Director		039-16-1613 Usual Residence of Decedent	1□M 2\(\overline{\text{F}}\)	79 Y	rs.			Jan 28	, 1927 M	assachusetts
	yland		10a. State 10b. County		10c. City, Town	or Location	1				10d. Inside City Limits
	8a-f s	ctor	MD		Baltim						1√2 Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exandractional Le mollified at Once.	by Funeral Director	10e. Street and Number 6401 Loch Raven	Blvd #332		10	f. Zip Code 212:	39		10g. Citizen of Wha	
	ams 2	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was C	Decedent of Hisp specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Race - Black,	American Indian, White, etc.
36	irs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 🖄 If Yes, Give Year or Dates:				Specify:		Specify:	white
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ylan	should be not Mental marked c	To B	Armand Roderick	Ferreira				Mary A	gnes Ch	aves	
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more,	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Surial 2 ☐ Cremation 3		Cametary	, cremator)	O OUISI PIACS)	i I			
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	40144		23a. Part . Enter the disease, or co shock or heart failure. List on	mptications that cause	the death. Do no		imore, Node of dying,			rrest,	Approximate
	Physician		shock or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each li	ne.	11	2 (24				Onset and Death
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Н	Examiner	Sequentially list conditions, at a consequence of.									
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P.0	requires that the de een signed by the nould be detached	/ Phy	Part II. Other significant conditions	contributing to death t	out not resulting in	the underly	ing cause given	in Part I.	23e. Did t	tobacco use contribu	ute to the cause of death?
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ivision	Attending r death. ector: Atterory the fune	catle	2 Accident investigat 3 Suicide 6 Could not	ho -		M	l 1 □ Ye	s 2 No	00(1	(0)	- Court Court All arts
<u>S</u>	l or At after o Direct J in by	Certification:	4 Homicide determine	200. Place of III	jury - At home, fan tc. <i>(Specify)</i>	m, street, fa	actory, office			Street and Number wn, State)	or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying I	Physicien: To the best	of my knowledge,	death occi	urred at the time	, date and place	and due to the	cause(s) and mann	er as stated.
	the H hin 24 the Fi	Medical	one)	and manner st	ated.	vor investig	29c. License r		ried at the time,	29d. Date signed (
	5 Wit		29b. Signature and title of certifier	ML	7						
			30. Na III and address of person wh	o completed cause of	death (Item 23a) (Type, Print)	1	1		~ ^	, ULL
			Michele F-Bellan	tani mo	550	5 /	typkop	Sign	en Circ	de Bald	7-200 (mm MD
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	Examir Funeral	ner	4a. Facility Name (If not institution, give Genesis Peting Par 5. Social Security Number 6. S	ex 7. Age (In yrs. la.	st birthday)	Parli If Under 1 Year	r Location of Death // // R If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Cc. County of Deal Batter 9. Birt	
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show hipportent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any Injury or other treumetic event, the Medical Exam are must be realth of an once.	by Funeral Director	5822 Shady Sprin 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	g Road 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		2123 as Decedent of H es, specify Cuba	7 Ilspanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	U.S.A. 14. Race - Ame Black, White	
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	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (19a. Informationship (19a. I	- Daughter	25 Fu	llerton	Heights A	Ave. Bal	City or Town, State, 2 timore, Mo Oc. Location - City or	1. 21236
Baltimore,	permit. Pages Department of Importent: If It eny Injury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature 1) Funeral Service Line) / Metro	o Crema	Jame and Addres	nc. Feb.16	6,2006	Baltimore	, Md.
Ba	Dermi Depa Impo eny ir		23a Perti Errer the disease, of companion shock, or heart failure. List only	4/4	740	01 Belai	Lass r Road Ba	sahn Fun Ltimore, respiratory arres	eral Home Md. 21236	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		acx ?	Dement				Onset and Death
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O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3 □E	ctopic pregnancy			23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed I should be det	by	Part II. Other significant conditions of	ontributing to death but not result	ting in the und	erlying cause giv	en in Part I.		acco use contribute to 2 □ No 3 □ Pr	t
I Record	The ate h page	Completed						24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of
on of Vital	ding Physicien: Th. h. After this certificate funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of D ath 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	3 DOA Oth	4 Nursing Hom		ce 6 Other (Spec	cify)
Division	el or Attending s after death. Il Director: After id in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ne, farm, stree			Bf. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Mospitel or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	Medical (one) 2 Medical Exam	ysician: To the best of my knowl niner: On the basis of examination and manner stated.	on and/or inves	stigation, in my o	pinion, death occurre	d at the time, dat	e and place, and due	to the cause(s)
	2	2	29b. Signature and title of certifier	1		29c. Licenso	0059423	29.	bruary 15	h, Day, Year) 2006
	10		30. N. e and address o erson who on the state of the stat	completed callse of death (Item 2) 5601 401 Reve	23a) (Type, Pr	int) BSHPro	FB106-#30:	3 Bulton	cajmo Z	1239
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			For State Registrar	State of Maryla		artment of Hertificate of L			jiene 0 0 6	04701
	4		1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	th Day Yea	3. Time of Death
	Physicia /Medic		Beatrice V. Nixor	1				January		10:00 PM
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
			3405 Dennlyn Road			Balti				
	Funeral		5. Social Security Number 6. Se	TM OFFICE	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	(Year)	irthplace (State or Foreign Country)
H	Director		214-05-2820 Usuel Residence of Decedent	87	115.			Feb 16,	1918 No	rth Carolina
	and a		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary Find	ţō	MD		Baltimo	ore				1√2 Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	be filed within 72 hours after death with the Maryland Hygiene. At Hygiene, and other than "neturel", or items 23a or 28a-f ehow event, the Macical Examiner must be molified at	Funeral Director	3405 Dennlyn Roa	.d		2	21215		USA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in 1 Armed Forces?	J.S. 13.	Was Decedent of His	spanic Origin? (Spen	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
0	or its	E.	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 📆 No	Specify:	, , ,	Specify:	
200	ure!',	d by	3 XWidowed 4 □ Divorced	Year or Dates:				1		
0	"net	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired;	ation luring most of worki	ng unk	16b. Kind of Busines	ss/Industry
7 7	within ene. then "	dE	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO 140 1 836 168130)	/		social se	curity adm
V	e filed within al Hygiene. I other than '	ပိ	17. Father's Name (First, Middle, Last)		1	unk	18. Mother's Name	(First, Middle,		currey aum
yland	d be ental ked c	To B					Rosa B	elle Ale	exander	
<u> </u>	should be nd Menta marked imatic ev	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	I Route Number	r, City or Town, State	, Zip Code)
Z	nd 2 alith a 27 is r trau		Stephen Nixon/son		3405	Dennlyn F	Road Balt	imore, N	MD 21215	
ā,	s 1 a of Hei item othe		20a. Method of Disposition	20b.		osition (Name of matory or other place			20c. Location - City	or Town, State
Ē	Page nent c nt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Specify	Mellioval Itotil State	,,	, ,				
Бантіто	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		21. Signatur, of Funer I Service Licen	Wade, Directo	r 22	2. Name and Addres	s of Facility	655 W	Baltimore	Stroot
מ	89 E 2 8		micel	10 Call	Ba	altimore,			Darcimore	. Dileet
			23a. Part 1. Enter the disease, or companies, or heart failure. List only	one cause on e ch line.				or respiratory arr	rest,	Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition	a scrite	Courd	we arre	st			Oriset and Death
	/Medical Examiner		resulting in death)	Du lo for as a conse	(to eaneup	M o . a .	24			
	LXammor	Ļ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	w Co	Bonary	event			
	ed sit	line	cause. Enter Underlying Cause (Disease or injury	Ch Kim Le	AKV	of H	hil.t.			
•	xecul and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a,copse	quence of):	1	Quican	<i>n</i> ~		+
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ŏ	The law requires that the death certific te has been signed by the attending p. sage 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		75			23d. Date of	delivery
מ	death e atte	icla	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Fe		□Ectopic pregnancy □ Other (<i>specify)</i>			Month	Day Year
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ecords	equir sen si ould		000	Tive freed	1-0 =	11412		1 🗆 Y	es 210 No 3□	Probably 4 Unknown
ပ္ပ	as be	pie	17 he	unatoig	17/61	HKITIIS		24a. Was a autop	sy prior	autopsy findings available to completion of cause of
r =		Completed						perfor		es 2 No
Vital	ician: Th certificate rector, pag	Be	25. Was case relerred to medical examiner?	11		0.5	26. Place of Deat	h (Check only o	ne)	
0	hys this al dii	2	1 ☐ Yes 2 No		ER/Outpatie		4 Li Nuising no		dence 6 Other (S	pecify)
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	i or A after Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)	,,		City or Tow		
	spita hours neral fillec		29a. Certifier 12 Certifying Ph	ysician: To the best of my k	nowledge, deat	th occurred at the tim	ne, date and place,	and due to the d	cause(s) and manner	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	nation and/or in	ivestigation, in my or	pinion, death occur	red at the time, o	date and place, and	tue to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	1		29c. License	e number		29d. Date signed (Me	onth, Day, Year)
			Mecu	I fetim t	2	(1)00	18550		04091	06
			30. Name and address of person who	completed cause of death (It	em 23a) (Type	Print)	6.400	r - /	21 / Su	te 120
			21 Date lind Water Con Vacat	Jan Kins	MI)	2300	GARGE	Jon P	iva.	21216
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FFR 1 7 2	32. Registrar's Sig	H A	side				
	riegist	- ell	FEB 1 7 2	006 Melion .	12 100					

			For Stata Registrar	State of Ma	ryland / I	Departme <i>Certifica</i>			Mental Hy	giene Reg. No	000	04702
	Physici	an	1. Decedent's Name (First, Middle, La: Skylar E.	Pollhar	nmer				2. Date of De	Da	y 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	tospita	1 Bo	y, Town, or Lo	ocation of Dea		- 1	County of Death	
Sup.	Funeral Director		5. Social Security Number 6. 9		(In yes, last bi	rthday) If Und Month		Hours Mir				place (State or Foreign intry) yland
	aryland show	<u>.</u>	10a. State 10b. County		10c. City, Tow		·					10d. Inside City Limits
	28a-f	Director	MD Baltim 10e. Street and Number	ore			e Riv	er		10a. Ci	tizen of What Cou	1 ☐ Yes 2X No
	th with	al Di	612 Lanoitan				21220			US		,.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of Health and Mental Hygiene. It is partment if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar ministic andilled at 0.5.0.	by Funeral	11. Marital Status ** Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		If Yes, s	pecify Cuban,	anic Origin? (Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	D-	14. Race - Ameri Black, White, Specify: Wh	, etc.
Maryland 21215-0036	within 72 horane. ane. then "nature	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-		life. DO NOT	vork done duri		orking		(ind of Business/Ir	ndustry
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ylaı	ould b i Menta narked natic e	To	Donald Pollham						Czwart			
Z	nd 2 shallth and 27 is n r traun		19a. Informant's Name/Relationship (Donald Pollha			612 La			ltimore		or Town, State, Zi _i	o Code)
Baltimore,	Pages 1 and ment of Heannt of Heannt of Heannt of Heannty or other		20a. Method of Disposition 1 Burial 2 Commation 3 4 Donation 5 Other (Specification)	Removal from State	20b. Place o	of Disposition (A ary, crematory of iewCre	lame of r other place) mator	y 2/	Date 17/06	Ba]	ocation - City or T Ltimore	MD
Balt	permit. Departi Import any inj		21. Signartire of Funeral Service Licer	Conne	lly		300 Ma	ice_Av	reBal	timo	eralHomore MD	eofEssex 21221
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cardi	the death. Do	1	Fail		ac or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	talis						4 months
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pheu	consequence	horax of):						/hr
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Ś	w requires that the sbeen signed by the should be detached		Part II. Other significant conditions of	ontributing to death bu	t not resulting i	in the underlying	cause given i	in Part I.	23e. Did	1	1	the cause of death?
II Reco	The law ate has b page 2 sl	Completed							24a. Was auto perfe 1 Ves		prior to co	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	4 7 5 5 7 6		Othor		eath (Check only	- 1		
Division of Vital Record	ding h. After fune	atlon: To	1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 X atien 28a. Date of Injury (Month, Day		Time of Injury M	28c. Injury at Work?		28d. Describe		6 ☐Other (Speci iry occurred	(y)
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical ((Check only 2 Medical Exar	ninar: On the best of and manner state	examination ar	nd/or investigati	on, in my opini	ion, death oc	ce, and due to the curred at the time,	date an	d place, and due t	to the cause(s)
1	To To	2	29b. Signature and title of certifier	R		2	9c. License ni RES	A	00		ate signed (Month,	Day, Year)
	1		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, Print)	0.0	- / -	oo lare, M	10	1	12,000
1		• 0	Rachel Raw 31. Date filed (Month, Day, Year)	(4 O C) N,	Wolfe	Stb	altim	iore, M	aryl	and Z	128 1
	Sta Registr		FFR 1. 7.2	006	A A	South.	9			J		

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Anna V. Potter February 14, 2006 9:00 p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore city N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 70 219-26-5344 Yrs. Director 01-20-1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ X MD Carroll Director Westminster 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 3850 Flickinger Rd. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 end 2 should be filed within ertment of Heelth and Mental Hygiene. ortant: if item 27 is marked other then injury or other treumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Retail 12 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lino Vidi Frida Widi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton J. Potter / Husband 3580 Flickinger Rd. Westminster, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: if any injury or once. Holly Hill Memorial Gardens 2-18-2006 4 Donation 5 Other (Specify) Middle River MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Rd. VIO Leonard J. Ruck, Inc. Balto., MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the ettending physicien and it be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificete 1 Yes 2 200 or Attending Physician: 25. Was case referred to edical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 1 Z Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturat
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) H0061206 of deat (Item 23a) (Type, Print) MANCHESTER, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

プu/(afica) G. Hibとし altimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:40 AM G. ALBERT PULIAFICO reb 15 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LEVINDALE HEBREW GERIACTRIC BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs. 5/20/1927 Director 216-20-3231 PENNSYLVANTA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 XNo Director **GLENDALE** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a USA 21239 6718 QUEENS FERRY ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KOREA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "neturel", or 1 ☐ Yes 2 X No Specify: þ WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) YEARS SENIOR VICE PRESIDENT BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be a Is marked COSIMO PULIAFICO MARY PULIO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2941 LONESOME DOVE ROAD MT. AIRY, MD 21771 Department of Health Importent: If Item 27 THERESA MCGUIRE/NIECE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition DULANEY VALLEY MEM. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/2006 * 4 ☐ Donation 5 ☐ Other (Specify) COCKEYSVILLE, MD GARDENS 21. Signature of Funeral Service License 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Physician hrome disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to limited date cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician 68760 Physician/Medical the use as Box IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. by 1 ☐ Yes 2 ☐ No 3 Probably 4 🔲 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital Yes 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3∏ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide within 24 hours e To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060 70 15 2006 ilk, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A, CHAZINOUIR, MD Www.d.J.L.Hebrew Geriactric Center & Hospital 2434 W. BELVEDERE 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FREDERICK T. PRECHT 5:08am February 12, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore <u> Greater Baltimore Medical Center</u> Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **3**M 2 □ F Months Days Hours Director 88 220-03-2466 7/22/1917 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other then "natural", or itema 23a or 28a-f show traumatic event, the Musical Exertices count by notified at Director 1 ☐ Yes 2 ☐XNo MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7830 WESTMORELAND AVENUE Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HARDWARE WAREHOUSE 12TH GRADE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental permit. Pages 1 and 2 should be Department of Heelth and Menta Important: if item 27 is marked any injury or other traumatic events. 2 CHARLES F. PRECHT CATHERINE DARNALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE V. PRECHT/WIFE 7830 WESTMORELAND AVE. PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2
Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 2/16/2006 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Sign, ture of Funeral Service Licensee Jal 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Nan /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and is the burial-transit The law requires that the death certificate be executed Van len that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) n signed by the a ld be detached f o. 9 Unknown 9 Unknown ۵ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ cete has been sig , page 2 should b 1 Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 20 No 1 ☐ Yes Vital Attending Physician: : After this certification tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes_ 20 No npatient မှ 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Many r of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funerel Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide o the Hospital or 29a. Certifier 🔯 Certifying Physician: To the heet of my knowledge disath occurred at the time, date and place, and due to the nause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 06 30. Name and Iddress of person who completed cause of death (Item 23a) (Type Print) 5H OWSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 06706 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Virginia Plackovich February 10, 2006 2:24a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice N/A Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 15, 1 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 21 F Yrs. 212-05-2519 Director 1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthen "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at Baltimore Marvland N/A 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 338 S. Mount Street 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Operator Switchboard of Heelth and Mental Hygie item 27 le marked other t r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Car1 Klein Josephine Hartzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a
Department of Heelth ar
Important: If item 27 le
eny injury or other trsu Kimberly Mitchell (Granddaughter) 489 N. Patuxent Rd., Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2/17/06 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Lend Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon cancer unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him colors cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1-Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by in by 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 February 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Tso MD Richey

FEB 1 7 2006

31. Date filed (Month, Day, Year)

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ackovich

N. Eutaw

Baltimore MD

838

32. Pagistrar's Signature

Hospice

Keith Perry 06-00436 CT

	1	Unpend item# 	- 1	,		tificate			21102 141		g. No.	U b	U4/	0 /
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Physician /Medical	-	Keith Per	ry							January		2006	8:40	P^{M}
Examiner		4a. Facility Name (If not institution, give :	street and numb	oer)		, , ,		Location of				nty of Death		
		410 Cedar Avenue 5. Social Security Number 6. Secu		A (I=		Fort If Under		hingt If Under		0.00-1(0:4)	Prir	ice Geo		
Funeral Director			M 2 F	Age (In yrs.) 49	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, July 21,	^{Year)} 1956	9. Birthp	lace (State or try) ington	r Foreign
	-	Usual Residence of Decedent								July 21,	1730	Wasii	ington	, DO.
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by th		3 Suicide 6 Could not be determined	28e. Place o	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory	, office		- 2	28f. Location (St.		mber or Rura	l Route Numi	ber,
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thin 24 hour the Funer mplately fill	ומו	(Check only Medical Exami	ner: On the bas and manne	is of examina	tion and/or in	vestigation,	in my or	oinion, dea	th occurre	ed at the time, da	ate and place	e, and due to	the cause(s))
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		Hamit Swither	11 MM				OCME	₹.		т	ัลทบาวชา	y 18,	2006	
		30. Name and address of person who co	mpleted cause	of death (Item	23a) (Type,		JOIT	7152			andat,	10,	2000	
		Pamola E. Smit	hail or	V)		111	Per	ın Stı	reet	Baltim	ore. I	Mar v1 o	nd 212	01
		31. Date filed (Month, Day, Year)												

			1 - For State Registrar		State of M	larylar	-	artmen rtificat				lental Hy	giene Reg. No.	06	04708
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	Funeral Director		5. Social Security Number 215-48-775	r 6. S			last birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bir (Month, Da May 25	th ay, Year) , 1950	Coun	ace (State or Foreign try) n Carolina
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Baltimore,	permit. Pages 1 and Depertment of Healt Important: if Item 2: any injury or other i		20a. Method of Disposition 1 Structural 2 Cre 4 Donation 5 0	mation 3			Place of Disponentery, crements Groven				Feb. 200		Mt. A	iry. M	
Balt	permit. Depertr Imports any inj		21. Signature of Funeral	Service Light	See All	2		Name an			ty	25.00	ne & Cr Winfi	957187	
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ot <	Physician: this certific	10	1 ☐ Yes 2 K No		Hospital: 1 1 Inpat		ER/Outpatier	nt 3□ DO	A Othe	9r. 4 □ Nu	ırsing Ho	me 5□Res	dence 6 □C	ther (Specify)
L C	After	atlon;	2 Accident	Pending investigation	1	ury a <i>y Year)</i>	28b. Time o Injury	f 2	8c. Injury Work	at :? Yes 2 □		28d. Describe	how injury occ	urred	
Divi	ital or Att rs efter d ai Direct led in by (Certification:	3 ☐ Suicide 6 L 4 ☐ Homicide	Could not be determined	286. Place of II	njury - At h etc. <i>(Specil</i>	ome, farm, str	eet, factory	, office				Street and Nur wn, State)	nber or Rural	Route Number,
	To the Hospital or Attentwithin 24 hours effer death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the bes niner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, ath occurr	and due to the red at the time,	cause(s) and a date and place	manner as sta e, and due to	ated. the cause(s)
	To T Con	Σ	29b. Signature and title o	f certifier	M.D.			290	License	585	80		29d. Date sign	ned (Month, E 5 200 C	
	10		30. Name and address of BA1 KAN			death (Iter		Print)	Bows			0715			
	Sta Registr		31. Date filed (Month, Da		32. Regis	trar's Signa	ature	berk	,						

		1	For State Registrar	State of Marylan		artment <i>tificate</i>			nd Men		ene g. No. 0 0	18	0470	9
8			Decedent's Name (First, Middle, Last)							Date of Death	Day	Year	3. Time of Dea	ath
	Physicia		Charles			Pie	((6	2	1	bruary		006	14:30	, м
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	own, or	Location of	Death		4c. County	of Death		
	LAGIIIII	•	The Johns Hopk	ins Hospital				none (city					
	Funeral		5. Social Security Number 6. Sex			If Under 1 Months	Year Days	If Under 2 Hours	Min. (Date of Birth Month, Day,		9. Birthp	lace (State or Fo	nk
	Director		218-36-6651	M 2□F 65	Yrs.				Ma	ar 20,	1940			
	D .	-	Usual Residence of Decedent 10a. State 10b. County	10c, Cit	y, Town or Lo	cation						1	Od. Inside City L	imits
	sho	2	,		Baltimo								1. Yes 2[□No
	he N	Director	MD 10e. Street and Number	1	Dartime	10f. Zip 0	Code			10	g. Citizen of \	What Cour	ntry?	
	with with	Dir	2316 E. Fairmour	nt Avenue				21224			U	SA		
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Itams 23c or 28e-f show yeth. The Medical Examine must be notified a	Funerai		12. Was Decedent Ever in U	.S. 13.	Was Decede			in? (Specify Puerto Rica	Yes or No-			can Indian,	
	fter d	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No					, Риепо ніса	in, etc.)		ck, White,		
036	urs a		3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X NO	Specify:				whi		
21215-003	72 ho	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual	done o	during most	of working	unk	16b. Kind of B	usiness/In	dustry	unk
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired) -						
2	ed wi	Co	unk ur	ık				19 Mother	r's Name /Fi	rst Middle A	faiden Sumar	me)		
_	m - 0 %	Be	17. Father's Name (First, Middle, Last) Charles Pierce					18. Mother	Helen			,,,,,		
<u>}</u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	၉		na Reinth	10h Maili	na Address	(Street :	and Numbe			City or Town	State, Zir	Code)	
Maryland	12 sh h and 7 Is m		19a. Informant's Name/Relationship (T) Johns Hopkins Ho							imore,		1287		
e,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a one.		20a. Method of Disposition	20b. F	Place of Dispo	osition (Nam	e of		Date	1	20c. Location	- City or T	own, State	
Baltimore,	ages nt of If it		1 Burial 2 Cremation 3 F	lemoval from State	cemetery, cre	matory or ot	ner piac	(e) 						
뜶	it. P.		*4 □ Donation 5 ☑ Other (Specify) 21. Signature → Funeral Service Licens		2	2. Name and	d Addres	ss of Facility	у	-				
Ba	Deparent Deparent Import any ir		Ronald S. I	lade, Virgico	r S	tate A	nat	omy Be	oard 6 21201	55 W.	Baltim	ore S	Street	
			23a. Part1. Enter the disease, or comp	ications that caused the dear									Approximate Interval Between	en
			shock, of heart failure. List only o Immediate Cause (Final		O'T and								Onset and Dea	
	Fnysician /Medical		disease or condition resulting in death)	a Pncumor Due to (or as a consec									2000	
H	Examiner			Lung A	denoc	carcin	NOW	na					2 weeks	
	200	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec										
	ou ed	Exar iner	that initiated events	c										
ó	e exer		resulting in death) Last	Due to (or as a consec	quence of):									
8760,	death certificate be execused e attending physician and of for use as the burial-transit	licai	•	d										
9	leath certifica attending ph	e e	IF FEMALE:	20 If you autooma of progra	0.004						224 0	ate of deliv	(0.0)	
Вох	ath ce ttend or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of	al death 3	□Ectopic pro		/				lonth	Day Yea	ar
0.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ueaui 5	□ Ottiel (Spi	ocny) _							
0	The law requires that the de tte has been signed by the a page 2 should be detached		Part II. Other significant conditions co	intributing to death but not re	sulting in the	underlying ca	ause giv	en in Part I		23e. Did to	bacco use cor	ntribute to	the cause of dea	ith?
ds,	signe d be	d by								1 □ Y	es 2 🗆 No	3 Pro	babiy 4 ∐Uni	known
Records,	v require been sig should b	ompieted								24a. Was a	ın 24b.	. Were au	topsy findings av	ailable
3ec	has be 2	dm								autops	med?	death?	ompletion of cau	se or
		င်	25. Was case referred to medical					26 Place	a of Death ((1 ☐ Yes Check only or	2 No	1 103	20.10	
Vital		o Be	avaminar?	Hospital: 1 Apatient 2	☐ ER/Outpatie	ent 3 DC	Ott	oer.	H = 1-1	1000	ence 6 🗆 Ot	ther (Spec	cify)	
of	Phys or this eral di	}	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		8c. Injui	ry at	280	d. Describe h	ow injury occu	rred		
lon	Attending In death.	tio	1 Natural 5 Pending 2 Accident investigation		injury	М		Yes 2□	No					
Division	l or Attendii after death. Director; A	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s	treet, factory	, office		281	Location (S City or Tow	treet and Nun n, State)	nber or Ru	ral Route Numbe	3 <i>I</i> ′,
Ö	s after s after el Dire ed in b	Certification:												
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my kr niner: On the basis of examin	nowledge, dea nation and/or i	ath occurred investigation	at the ti	me, date ar opinion, dea	nd place, and ath occurred	d due to the o at the time, o	ause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
	the H in 24 the R	Medi	one)	and manner stated.				se number			29d. Date sign			
	To To	~	29b. Signature and title of certifier Computer Comp	Listing Of Ser	Ortho						_		2006	
							Kes	- 000	٥		-e-wall	5 4,	00	
			30. Name and address of person who	completed cause of death (It	em 23a) (Type	s. Mosa:	al.	600 No	oith Wo	ife Stree	+, Balhm	wre, M	aryland Z	:28
	-	tate	31. Date filed (Month, Day, Year)	32. Pagistrar's Sig							1			
	Regis		FFR 1 7	2006	A A	forth	*							

			1 = For State Registrar	State of M		d / Depa		t of H	ealth a		ental Hy		006	04710
	Physicia		1. Decedent's Name (First, Middle, La Elizabeth Quill	ast)							2. Date of De Month 2	13 ^{Day}	2008	3. Time of Death 2:50 p M
	/Medic Examin		4a. Facility Name (If not institution, gi 7903 Orion Circle #		ar)		4b. City, Laur		Location o	f Death			County of Dea	
	Funeral Director		218-01-0020	Sex 1 □ M 2 🗘 F	Age (In yrs. I. 91	ast birthday) Yrs.	ff Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Bi (Month, Da 7 29	rth a <i>y, Year)</i> 1914	9. Bi <i>M</i> a	rthplace (State or Foreign Jountry) ryland
	faryland start	or	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orge	10c. City	r, Town or Lo	cation					****	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1)XXYes 2 □ No
	with the Na or 28s-	l Direct	10e. Street and Number 7903 Orion Circle #4				10f. Zip	Code 0724				-	en of What C	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? XNo		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ecify Yes or Ne Rican, etc.)	-	4. Race - Am Black, Wh Specify: Wh	
Maryland 21215-0036	a within 72 ho pene. rthan "naturi the Medical I	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation rade completed) College (1-4c	or 5+)		dent's Usua kind of woi DO NOT us memakei	rk doné a se retired,	ition luring most)	of workii	ng		d of Business	,
land	uld be filed Mental Hyg irked other itic svent,	To Be C	17. Father's Name (First, Middle, Las Melvin M. Phelps	t)							(First, Middle Shaffer		Sumame)	
, Mary	and 2 sho laith and h 27 is ma er trauma		19a. Informant's Name/Relationship Elizabeth L. Quill/o				ng Address Orion (r or Rura	l Route Numb	oer, City or	Town, State,	Zip Code)
Baltimore,	Pages 1 and the nent of He nent of He nent of He nent of He nert or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control Cont		to CE	lace of Dispo emetery, cren • Mary !	natory or o	ther place		2 17	7 2006		ation - City o	r Town, State land
Balt	Departi Departi Importi sny inj		21. Signature of Vineral Service Lice	- hullo			. Name an 601 Sai				eck Fune Laurel,			07
760,	Physician // Medical // Medical // Medical // Examiner // Italian	dical Examiner	23a. Part1. Entel the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneui Due to (or : b. Due to (or :	monia as a consequ as a consequ as a consequ	uence of): uence of):		1						Interval Between Onset and Death
.O. Box 68	that the death certifica ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pr Other (sp					2	3d. Date of de Month	elivery Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions	contributing to death	n but not r <i>e</i> su	ulting in the u	nderlying c	aus <i>e</i> give	n in Part I.					to the cause of death? Probably 4 \mathbb{Y}Unknown
	ilcian: The law requires certificate has been sign ector, page 2 should be	e Completed	25. Was case referred to medical						OS Blace	of Dooth	1 ☐ Yes	omed? 2 No	prior to death?	autopsy findings available completion of cause of
>	9 0 =	o Be	examiner? 1 ☐ Yes 2√ No	Hospital:	atient 2 🗆 l	ER/Outpatien	it 3□ DC	A Othe	·-		(Check only ne 5 ∑ Res		Other (Sp.	ecify)
	Attending Phyrden and the sector: After this by the funeral c	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	on	njury Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at	2	28d. Describe			
	Hospital or Att t4 hours after de Funeral Direct tely filled in by t	Certification:	3 Suicide 6 Could not lead to determined	280. Place of	fnjury - At ho etc. (Specify	me, farm, str	eet, factory	, office				(Street and wn, State)	Number or F	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Aedicai	(Check only 2 Medical Exa	hysician: To the be miner: On the basis and manner	s of examinat	wledge, death tion and/or in-	vestigation.	in my op	inion, deal	d place, a	and due to the	, date and	place, and du	e to the cause(s)
	vit To To	2	29b. Signature and title of certifier	all				: License 024997					signed <i>(Mor</i>	oth, Day, Year)
	6		30. Name and address of person who Luis Casas 8317 Ch		•			07						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	atrada Ciga at									
1000			FEB 1 7 200	The state of the s	, ,,,	17								

	1- State of Maryland / Department of State of Maryland / Department of Certificate of Certi		CUUU U4/11
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day, Year 6.5.1
/Medical	DOROTHY RACHEL REYNOLDS 4a. Facility Name (If not institution, give street and number) 4b. City, Tox	vn, or Location of Death	13,2006 1.04 P M
Examiner	ST. Agnes Hospital Bal	timore	N A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		9. Birthplace (State or Foreign Country) MD
P	Usual Residence of Decedent	04. 24. 1-	
Maryla f shov	10a. State 10b. County 10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1
r 286-	10e. Street and Number 10f. Zip Co	de 10g.	. Citizen of What Country?
ath witi	4148 DRAYION GREEN 2	1221	USA
iter death with the Mar fritems 23e or 28e-1 si frite must be codified Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 13. Was Decedent If Yes, specify	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)	 Race - American Indian, Black, White, etc.
D36	If Yes, Give 1 ☐ Yes 2 ☑ Year or Dates:	No Specify:	Specify: BLACK
ed within 72 ho sgiene. The Madical it, the Madical it.	15. Decedent's Education 16a. Decedent's Usual C (Specify only highest grade completed) (Give kind of work of	lone during most of working	b. Kind of Business/Industry
vithin within see.	Elementary/Secondary (0-12) College (1-4or 5+) 12 / LL GRADE N A CUSTODIAN		ALTIMORE COUNTY
ind 2 be filed tal Hygin event, it	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Main	
should be nd Mental marked of Immail: evo	KICHARD BLACKWELL, SR.	MARY LAWRENCE	
Maryland of 2 should be file th and Mental Hy ty 1e marked oth traumatic event	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (S DOREEN REYNOLDS (DAUGHTER) 51 WINTER	treet and Number or Rural Route Number, Ci 3 LANE CATONSVILLE	
re, s tan f Heal item 2	20a. Method of Disposition 20b. Place of Disposition (Name	of Date 200	c. Location - City or Town, State
Page Page ment of ury or	1	' '	LTIMORE MD
Baftimore, Marylar permit. Pages 1 and 2 should be Deperment of Health and Menta important: if them 27 te marked emy injury or other traumatic engage.	21. Signature of Funeral Service Licensee 22. Name and A VAUGIIN 5151 BAUTO	Oddress of Facility GREENE FUNERAL NAT. PIKE, BALTO. MO	SERVICE
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line.		
Physician	Immediate Cause (Final disease or condition Ar toxio and	erotic Vaswler 1	Distance Unknown
/Medical Examiner	resulting in death) Due to (or as a consequence of):		
K.	Sequentially list conditions, if any, leading to immediate course. Each I laderbing to immediate course. Each I laderbing to immediate course.		
5), C executed in and in-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
\$8760, Corrected to the second of the second	Due to (or as a consequence of):		
68760 ilicate be e physician as the buris			
Sox th cert tending r use	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregrament	nancy	23d. Date of delivery
ecords, P.O. Box 68760, — law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit bliefed by Physician/Medical Examir	in the past 12 months? 1		Month Day Year
that the sed by detac		e given in Part I. 23e. Did tobac	cco use contribute to the cause of death?
rrds, an signe and be a by		1 Tyes	2 No 3 Probably 4 Unknown
0 0 0 20 0		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Recuiring The law incian: The law incian: The law incian: The law incian; The law incian; Page 2		performed	d? death? No 1 ☐ Yes 2♥No
Vita Vita sician sician certificiector iractor	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛇 40 Hospital: 1 ☐ Inpatient 2 X = R/Outpatient 3 ☐ DOA	26. Place of Death Check only one Other:	
g Physi g Physi en this c neral dire		Injury at Work? 4 Nursing Home 5 Residence 28d. Describe how work?	
Sior lendin eath. or: Afr ihe fur	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 Yes 2 No	
Division control of the control of t	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice 28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
		he time, date and place, and due to the caus	se(s) and manner as stated.
o the Hosp iffnin 24 hou o the Fune ompletely fill	one) and manner stated. 29b. Signature and title of certifier 29c. L		. Date signed (Month, Day, Year)
F 3 F 5			
đ	30. Name and address of person who completed cause of death (Item 23-) (Type, Print)	1-20	Deltmon Arryland
	31. Date filed (Month, Day, Year) 32. Registrar's Signature	94 Cepen Avene	B. Hinore Maryland
State Registrar	31. Date lifet (Monal, Day, Fear)		

Director

δ

Completed

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Yrs.

7. Age (In yrs. last birthday)

73

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Wilbert Thomas Rogers, Sr.

Month

2. Date of Death Day 13,2006 5:40A M February

Funeral Director

other then "natural", or itema 23a or 28a-f ehow rent, the Medical Examiner must be notified at

death

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

is marked

permit. Pages 1 and 2 s Department of Health ar Important; if Itsm 27 is any injury or other trau

Physician

/Medical

tran-

attending physician a for use as the burial

ed by the detached

page 2 s

certificate

this After this

after death Director:

within 24 hours a

To the Funeral C

completely filled

death.

Examine

Completed by Physician/Medical

Be

ဥ

Certification:

Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Baltimore, Maryland 21215-0036

4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

4c. County of Death M/A

5. Social Security Number 245-48-8898 Usual Residence of Decedent

10b. County

10c. City. Town or Location

8. Date of Birth (Month, Day, Year)
May 13,1932 N. Carolina Birthplace (State or Foreign Country)

10g. Citizen of What Country?

10a. State

Maryland N/A

Baltimore 10f. Zip Code

10d. Inside City Limits 1 ☑ Yes 2 ☐ No

10e. Street and Number

5950 Green Meadow Parkway

17☑M 2□F

21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA 14. Race - American Indian, Black, White, etc.

Funeral 11. Marital Status

1 Never Married Married 3 Widowed 4 Divorced

1 ☐ Yes 2 ☐XIo Specify:

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry Baltimore City Dept. of Education

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12) 8th Grade

John Rogers

18. Mother's Name (First, Middle, Maiden Sumame) Louise Branch

19a. Informant's Name/Relationship (Type, Print) Bettie J. Rogers/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5950 Green Meadow Pkwy Baltimore, MD 21209

20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) 2/18906 Zion Bapt. Ch. Cem.

Seaboard, NC

20c. Location - City or Town, Slate

21. Signature of Funeral Service Licensee er 7 Danis

22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, MD 21215

23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cardiac amythomias Due to (or as a consequence of):

Approximate Interval Between Onset and Death 1 HR

Immediate Cause (Final disease or condition resulting in death)

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

other use brutic	heamt	disece	ie
ue to (or as a consequence of):	71-7		

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diobeter mellitus Hyperstonsian, convertile heart

1 ☐ Yes 2 ☐ No 24a. Was an

3 ☐ Probably 4 ☑ Cinknown

Jeilure

autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 ☑ No

27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury al Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Prasidence 6 Other (Specify) 28d. Describe how injury occurred

4 Homicide

2 Accident

3 🗌 Suicide

investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D36494 29d. Date signed (Month, Day, Year) - 2-16-2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

710 Maiden chaice lane DESAI

State Registrar 31. Date filed (Month, Day, Year) 7 2006 FEB 1



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

10:45 RM

2. Date of Death

February 15, 2006

			1 - State Registrar		
	Physici	an	Decedent's Name	e (First, Midd	le, Last)
	/Medic	al	Allei 4a. Facility Name (/	n Pat	
7	Examin	er		ndsor l	
	Funeral		5. Social Security N		6. Sex
	Director		215-30-5		1 X
	land ow		Usual Residence of 10a. State	10b. Count	y
	Mary Ff ⊕h	to	Maryland	Balti	more
	th the	Irec	10e. Street and Nu		mo į. o
	eth wi	ral	7519 Wi	ndsor	M111
	er de	une	11. Marital Status		
36	rel', or P	by F	1 ☐ Never Marr 3 🌠 Widowed	ied 2 Ma 4 Divorce	
2-0	2 hou	ted	/S	15. Decede	nt's Edu
121	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Many Depertment of Heelth and Mental Hygiene. mportant: if item 27 is marked other then "naturel", or iteme 23a or 28e-f ehany injury or other traumatic event, the Medical Examination at the notified and injury.	Be Completed by Funeral Directo	Elementary/Seco	ondary (0-12)	751 Grade
d 2	filed Hygin other	C	17. Father's Name	(First, Middle	, Last)
ıan	Aental Aental rked tic ev	To B	John	Raymo	nd
/ar	2 sho and h is ma		19a. Informant's N	ame/Relation	
e, l	1 end Heelth em 27 ther t		20a. Method of Dis		ушоп
mor	permit. Peges 1 end 2 should be filed Depertment of Heelth and Mentat Hyg mportant; if item 27 is marked othe any injury or other traumatic event, 2008.		_	Tremation 5 Other (
Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other then "naturel", or Iteme 23a or 28e-f ehow any injury or other traumatic event, the Madical Examinat must be notified at Quee.		21. Signature of Fu	neral Service	License
			23a. Party Enter t	the disease,	or compli
J	Physician		Immediate Cause	rt failure. Lis (Final	it only or
4	/Medical		disease or condition resulting in death))ri	-
ı	Examiner		Sequentially list co	onditions.	
	be sit	lner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	ł
1	and and Il-tran	Examine	that initiated event resulting in death)	S	0
09/	sicien buria	alE			•
68760,	certificate be executed ding physicien and se es the burial-transi	Medical			
XO	ā <u>=</u> 0		IF FEMALE: 23b. Was deceden		2
O. E	e dea the ett	sich	in the past 12 1 Yes 2 9 Unknown	□No	
Ρ.	that the sed by detach	Phy	Part II. Other signi		tions cor
ds,	uires l signe	d by	Ch	ahe	•
S	w req	lete		14	4/h
Division of Vital Records, P.O. Box	if or Attending Physicien: The law requires that the death or affer death. Director: Affer this certificete hes been signed by the ettend in by the funeral director, page 2 should be detached for us	ertification; To Be Completed by Physician/			(\1
ital	stan: artifice ctor, p	3e C	25. Was case refe examiner?	rred to medic	-
of V	hysic this ce	To.	1 ☐ Yes 2 N	No	F
on c	Jing F	lon	27. Manner of De	5 Pend	
isk	or Attend after death Director: /	flcat	2 ☐ Accident 3 ☐ Suicide	6 Could	d not be
Div	after Direction by	erti	4 Homicide	deter	mined

Allen Patric	k Raymond, Sr				rebluary	13, 2000	10:45 km
4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D	eath	4c. County of Deat!	h
7519 Windsor Mil	1 Road		Windsor	Mill		Baltimor	e
5. Social Security Number 6. 5	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	9 Birth	nplace (State or Foreign
215-30-5249	X 2 F 71	Yrs.	Months Days	Hours A	January 29		untry)
Usual Residence of Decedent	11 / 1				January 23	TOOU TEM	Syrvania
10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	W	indsor	MITT				1 ☐ Yes 🏋 ☐ No
Maryland Baltimon	re	Indoor		-			
10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
7519 Windsor Mil	L1 Road #A		21244		Uni	ted States	of America
11. Marital Status	12, Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame	
1 Never Married 2 Married	1 X es 2 □ No				dello ricari, etc.)	Black, White	
3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite
15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business/	Industry
(Specify only highest gr		(Give	kind of work done DO NOT use retired	during most of	working		•
Elementary/Secondary (0-12)	College (1-4or 5+)					Merchant	marine
	0	merch	ant Seam		Name (First, Middle, M	folder Comment	
17. Father's Name (First, Middle, Last)					alden Sumame)	
John Raymond				Alice	Aiken		
19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number o	r Rural Route Number,	City or Town, State. 2	(ip Code)
A. Patrick Raymo	ond, Jr.	9906	Eldee D	rive, e	llicott Ci	ty, MD. 21	042
20a. Method of Disposition	20b.	and the second s	sition (Name of matory or other pla			Oc. Location - City or	
1 Burial 2 XX remation 3 [John Colling State						
4 ☐ Donation 5 ☐ Other (Speci			ematory			altimore,	Maryland
21. Signature of Funeral Service Lice	nsee	22	2. Name and Addre	ss of Facility ${f L}$	oring Byer	s Funeral	directors,I
hough 1- 1	Collinar Noc	3.33	8728 Lib	erty Ro	ad, Randal	lstown, Ma	ryland 2113
23a. Party Enter the disease, or con							Approximate
	one cause on each line.						Interval Between Onset and Death
Immediate Cause (Final disease or condition	, (\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	(a-c	sh al	100	retim		
resulting in death)	Due to (or as opns	equence of):					
	(and	~ /	mte	3/	elmes	(
Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	eque ce of):		Å			
cause. Enter Underlying				U			
that initiated events resulting in death) Last	C. Due to (or as a conse	aquence of):					
	000 10 (51 40 4 001101	5 qualito 51/1					
	_ d				· · ·		The Company
15 5511115						1000	
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		3-			23d. Date of del	ivery
in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of		JEctopic pregnanc Other (specify)	у		Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Pod II Other significant conditions	contributing to death but not r	anultina in the		on in One 1	22a Did tob	acco use contribute to	the seven of death?
Part II. Other significant conditions	^^ 1	asulting in the d	riderlying cause gr	voit in Faiti.			•
- Babel	o , mui	<u>د ځا د</u>			1	s 2□No 3□Pr	obably 4 Unknown
1 the	no Ornal	IMIZ	_		24a. Was ar	24b. Were au	itopsy findings available
	100 00 11.00	\			autopsy perform	y prior to oned? death?	stopsy findings available completion of cause of
	1 Hypes	um.	∼ .			No 1□Yes	2 🗆 No
25. Was case referred to medical examiner?	· \			26. Place of	Death Check only on	6	
1 ☐ Yes 2 No	Hospital: 1 la atient 2	☐ ER/Outpatier	nt 3 DOA	ner: 4 □ Nursii	ng Home 5 Reside	nce 6 Other (Spe	city)
27. Manner of De th	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju Wo	ry at	28d. Describe ho	w injury occurred	
1 Natural 5 ☐ Pending 2 Accident investigation		Injury		rk?]Yes 2.∏No			
3 Suicide 6 □ Could not	De Disse of lainer At	home farm et				reet and Number or Ru	iral Route Number
4 Homicide determined	building, etc. (Spe	city)	ioot, ractory, unice		City or Town		aran noute realities,
29a. Certifier 1 Certifying P	hysicien: To the best of my k miner: On the basis of exami	nowledge, deat	h occurred at the ti	me, date and p	place, and due to the ca	use(s) and manner as	stated.
one)	and manner stated.	nation and/of in	vestigation, in my (pinion, death (occurred at the time, da	ite and place, and due	to the cause(s)
29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
	SAC.	ANYA P	101	nn (-	1420	02112	100
1000	one	MI	الااد	000	1731	0~11/	00
30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print)				12/13/5
SOSKNY	- Ato Wi), 53	11 OLD	Cour	I RD KA	MOAUSTO	MN, MID
31 Date filed (Month Day Year)	6 32 Registrare Sin	nature			7		,

DHMH 17 Rev 1/2001

State

Registrar

FEB 1 7 2006

31. Date filed (Month, Day, Year,

32. Registrar's Signati

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene ()	06	04715
		ш	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physici /Medi		Viola Rodo	wsky				Heb	Day	2000	1556 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. Cou	inty of Death	
			Franklin sa	yase Hos	pital	ROSO	2 mil	e.	Ba	1+, N	2050
	Funeral		5. Social Security Number 6. Se	x 7. Age (In)	rs. last birthday,	If Under 1 Yea				9. Birthp	ace (State or Foreign
	Director		218–26–3531	^{□ M 2}	Yrs.	Months Days	Hours M	Min. (Month, Da Sept. 16		Wisco	
	<u> </u>		Usual Residence of Decedent								1916/11
	thow thow	_	10a. State 10b. County		City, Town or L	ocation				10	Od. Inside City Limits
	Ba-f-	cto	Maryland Baltimore	Es	sex						1 ☐ Yes 2% CMNo
	in 2 2	Director	10e. Street and Number	3		10f. Zip Code				of What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or iteme 23a or 28a-f show ent, the Madical Esaminal must be notified at	la l	2329 Barrison Poin	t Road		212	21		U.S.A	Α.	
	de m	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		Race - Americ Black, White,	
36	ori	Y	1 Never Married 2 Married	1 ☐ Yes		1 ☐ Yes 2 ☐ No	Specify:		Spe	ecify:	
8	uraf.	Completed by Funeral	3XXVidowed 4 □ Divorced	Year or Dates:	100						nite
7	net net	lete	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	(Give	dent's Usual Occu kind of work done DO NOT use retir	during most of	working	16b. Kind o	f Business/Inc	lustry
12	P P P P P P P P P P P P P P P P P P P	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	80)		Own I	Tomo	
22	Hygid nt, n		17. Father's Name (First, Middle, Last)	<u> </u>	TIONE	ananer	18 Mother's	Name (First, Middle,			
an	od be	Be	Henry Hudson Grizz	oll				Elizabeth			
2	D Me Tark	ဥ	19a. Informant's Name/Relationship (T		19h Maili	ing Address (Stree		Rural Route Numbe			Codel
Maryland 21215-0036	d 2 s th an 7 te traus		Stanley Rodowsky,		1	-		Road, Balt			
ص ا	Healt Healt Healt ther		20a. Method of Disposition		b. Place of Disp	osition (Name of	1	Date		on - City or To	
٥	ages in tot		XX Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other pl	1			-	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Any injury or other traumatic event, the Medical Examinar must be notified at once.		4 □ Donation 5 □ Other (Specify)					5.15,2006			
Bal	Depermine of the permit of the		21 Signature of Edward Sorvice & Fam.		2	2. Name and Add	ruzdzins	ski Funera	al Home	e, P.A.	
			200 2001	lianting that account the		1407 O10	Easteri	i Avenue,	Essex,	, Marya	ilna 21221
п			23a. Part1. Inter the disease, or comp shook, or heart failure. List only o	ne cause on each line.	eath. Do not en	ter the mode of dy	ing, such as care	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Phei	imon	ia					
	/Medical Examiner		resulting in dealiny	Due to (or as a con-	sequence of):						
		_	Sequentially list conditions,	b. Due to for as a non	to an area of the						
	ed isit	lne	cause. Enter Underlying Cause (Disease or injury	Citia to (or as a riors	sion(warriga int):						
	and and I-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a con:	sequence of):						
8760,	cate be executed physicien and the buriat-transit	al E		000 10 (0. 00 2 00	204201100 017.						
87	phys the	dlcal		d							
9 ×	eath certific ettending p I for use as	Me	IF FEMALE:	23c. If yes, outcome of pre	onancy.						
Вох	aath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	□Ectopic pregnan	су		1	Date of delive Month	ry Day Year
o	the de	yslo	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9☐ Unknown	ordeath 5t	Other (specify)					
P.O.	The law requires that the death certificate has been signed by the ettending sage 2 should be deteched for use as	by Physician/Me	Part II. Other significant conditions co	ntributing to death but not	resulting in the I	inderlying cause o	iven in Part I.	23e. Did to	obacco use c	ontribute to th	e cause of death?
Division of Vital Records,	sign d be	5	•	•	•			101			ably 4 □Unknown
Ö	w requir been si should	Completed						-			
Sec.	hasl hasl	gu				 		24a. Was	sy	prior to con	osy findings available npletion of cause of
E		S						1 Yes	200 No	death?	2 □ No
<u>Si</u>	Physician: The ribis certificate har director, page	Be	25. Was case referred to medical examiner?	Ja anitalı				Death (Check only o	ne)		
5	F ==	ုင	1 195 2 340		☐ ER/Outpatie	III 3 DOA		g Home 5 Resid)
Ę.	After	ou	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	W		28d. Describe I	now injury oc	curred	
Sic	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No				
\leq	fler or Al	Certification;	4 Homicide determined	28e. Place of Injury · A building, etc. (Sp.	t home, farm, st ecify)	reet, factory, office	•	28f. Location (S City or Tox	Street and Nu vn, State)	imber or Rura.	l Route Number,
ш	urs a		On Continue (Constitute of	1/1/1							
	To the Hospital or Attending F within 24 hours attendesth. To the Funeral Director: After t completely filled in by the funera	Medical	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my iner: On the basis of exam	knowledge, dea nination and/or in	th occurred at the ovestigation, in my	time, date and pl opinion, death o	ace, and due to the courred at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. the cause(s)
	the thin the mple	Mec	29b. Signature and title of certifier	and manner stated.		29c Licer	ise number		29d Date sid	gned (Month, I	Day Veerl
	8 ≒≅≒		M//	4. *							
	-		NAME OF THE	M.D.		100	3	,13	0110	-100	
6			30. Name and address of person who c	ompleted cause of death ($NSMD$	Item 23a) (Type	Print)	aliana Na	W Rose	dale	MAN 7	1077
	/ 		Debra Helye 31. Date filed (Month, Day, Year)	32. Registrar's S	gnature -	unkun Se	zuureur!	VT KUSE	care	MI) &	105/
	Sta Registi		FFR 1 7 2006	Reserve A	60004						

	1 - State Registrar 1. Decedent's Name (First, Middle, La		/ Department of I Certificate of	Death		g. No.	3. Time of Death
ysician Iedical	JOHN		ROBINSON	1	Month FEBRUARY	Day Year 14 2006	0837 M
aminer eral ctor	4a. Facility Name (If not institution, given the second of	topkins Hospi	191 134/4	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	4c. County of Death Year) 9. Birthg Cour Pg, 1944 Rem	place (State or Foreigntry)
ateal Examiner mast be notilised at elect by Funeral Director	10a. State 10b. County	10c. City,	Town or Location			1	0d. Inside City Limits
ecto	N/A Pembroke	e Hamil	ton, Bermuda		10	Og. Citizen of What Cour	1 Tes 2 No
ai Di	29 Happy Valley H	Road	HM19			Bermuda	uy.
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 ☑ No	tispanic Origin? (Spec an, Mexican, Puerto R Specify:	ofy Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	cde completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Truck Driver	pation during most of workin d)	g	16b. Kind of Business/In Supermarket	dustry
Be	17. Father's Name (First, Middle, Last,		2401 322102	18. Mother's Name	(First, Middle, N	faiden Surname)	
2	Bernard Joseph Ro	Type, Print)	19b. Mailing Address (Street		Route Number,	City or Town, State, Zip	Code)
	Doreen James - Ft		51 York Streets of Disposition (Name of	et St. Geor			- C
	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State West	netery, crematory or other pla ey Methodist emetery	ce)		20c. Location - City or To Iamilton, Be	
once.	21. Signature of Funeral Service Licer		22. Name and Addre David J. W	ss of Facility leber Funer	al Home		
cian/Medical Examiner	23a. Pant1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) infarction noe of):	ig, such as cardiac of	respiratory arre	ISI,	Approximate Interval Between Onset and Death	
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1	eath 3 Ectopic pregnanc	,		23d. Date of delive Month	ery Day Year
<u>م</u>	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause gn	en in Part I.		acco use contribute to the	ne cause of death? pably 4 □Unknown
e Completed	25 West and the state of the st					prior to condeath? No 1 Yes	psy findings available mpletion of cause of 2 No
0	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 ★ npatient 2 ☐ EF	VOutpatient 3□ DOA Oth	26. Place of Death		nce 6 □Other (Specif	v)
atlon:	27. Manner of Death 1	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of 28c. Injury Wo			w injury occurred	,,
Certifi	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	21	Bf. Location (Str City or Town	reet and Number or Rura , State)	l Route Number,
Medical Certific	29a. Certifier (Crock only one) (Control only 2 Medical Example)	ysician: To the best of my knowle niner. On the basis of examination and manner stated.	edge, death occurred at the ti n and/or investigation, in my o	me, date and place, ar ppinion, death occurred	nd due to the ca d at the time, da	use(s) and manner as site and place, and due to	tated. o the cause(s)
×	29b. Signature and title of certifier	M.D.	29c. Licens	5-000	ì	Od. Date signed (Month, EBRUARY 17,	
	30. Name and address of person who	completed cause of death (Item 2	3a) (Type Print)				

State of Maryland / Department of Health and Mental Hy 1 - State Registrar Certificate of Death	ygiene 0 0 6 0 4 7 1 7
1. Decedent's Name (First, Middle, Last) 2. Date of D Month	
Medical Leona Vertie Rayman Februa	ry 15, 2006 0147 M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of 8	irth 9. Birthplace (State or Foreign
Funeral Section Number 1. Set	Day, Year) Country)
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code	1 ☐ Yes 2¶ No
4901 Philadelphia Road 21001	10g. Citizen of What Country?
4901 Philadelphia Road 21001 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Married 3 Married 4	lo- 14. Race - American Indian,
4901 Philadelphia Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 21001 12. Was Decedent Ever in U.S. Amed Forces? 1 Never in U.S. Amed	Black, White, etc.
10a. State 10b. County 10c. City, Town or Location Maryland Harford Aberdeen	Specify: White
Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0.12) College (1.4or 5+) Flementary/Secondary (0.12)	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)	Own Home
TO HOMEMAKEY 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle) 18. Mother's Name (First, Middle)	
James Gilmore Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num	eonard
- O.	ber, City or Town, State, Zip Code)
Q = can Himest H. Rayman / Son 4901 Philadelphia Poad Nhor	
cemetery, crematory or other place)	20c. Location - City or Town, State
	Bel Air, Maryland
21. Signature Funeral Service Licensee: Mic Contact Funeral Property Home, P.A. 1217 Colsosburg: Pond Abis	
23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one causable each line.	arrest, Approximate
Physician Immediate Cause (Final disease or condition resulting in death) A Due to (or s a consequence of): A Due to (o	Interval Between Onset and Death
Sagradio de la consecución dela consecución de la consecución de la consecución de la consecución dela consecución de la consecución de la consecución de la consecución dela consecución de la consecución de la consecución dela consecución de la c	
Examiner Sequentially list conditions, b. Intra Cardiac Shunt	
if any, leading to immediate Due to (or as a consequence of): cause. Enter Inderlying Cause (Disease or injury	
figure 1 and	
S8760 cate be cate be different the burning of the	
The state of the s	23d. Date of delivery
The past of the pa	Month Day Year
Yes 2 No 9 □ Unknown 9 □ Unknown 9 □ Unknown 9 □ Unknown 23e. Did Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	I tobacco use contribute to the cause of death?
T 0 2 52 6 ()	Yes 2 No 3 Probably 4 Unknown
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aut ger ser ser ser ser ser ser ser ser ser s	opsy prior to completion of cause of death?
U = 0 T V	
2 9 0 1 1 Yes 2 No 1 Spring Home 5 Re	sidence 6 Other (Specify)
27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Described 28d. Described	
	e how injury occurred
2 Accident investigation will less 2 1/40	
2 Accident investigation 3 Suicide 6 Could not be	e how injury occurred (Street and Number or Rural Route Number, own, State)
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29a. Certifier (Check only one) 29b. Signature and intelliged 29c. License number 29c. License number 29c. License number 29c. License number	(Street and Number or Rural Route Number, own, State) a rouse(s) and marker as stated at date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) February 15, 2006
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		1 - For State Registrar	State of Marylar	•	artment of F rtificate of			iene 006	04718
Physicia	an	Decedent's Name (First, Middle, Last ARTHUR)	D	UBINSTEIN	J	2. Date of Deat Month	Day Year	3. Time of Death
/Medic	- 0	4a. Facility Name (If not institution, give	street and number)			r Location of Deat	February	13th 2006 4c. County of Death	
	£ .	Sinai Hospit	al			more			N/A
Funeral Director		5. Social Security Number 6. Se 079-32-3541	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birth	nplace (State or Foreign untry) NY
D		Usual Residence of Decedent	0.0				001.0,1	340	
arylan ahow	5	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M	Director	MD N/A		BALI	I MORE		1	0g. Citizen of What Co	^
th with 23e or	a D	7241 PARK HEIGHT	S AVENUE #D			21208			USA
er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Modical Exportment or set the notified at once.	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ∏Yes 2 ሺ No It Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specity:		Specify:	WHITE
21215-0036 d within 72 hours at giene arthan "natural", or in a madical Exp. ii.	eted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	ation	nkina	16b. Kind of Business/I	ndustry
Mithin Mithin	Completed	Elementary/Secondary (9-12)	College (1-4or 5+)	lif⊖.	DO NOT use retired HANT MARI	d)	9	SHIPPING	
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/lan	To B	LOUIS		RUBI	NSTEIN	MINNI	ΙE	TAE	BACKMAN
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic avent		19a. Informant's Name/Relationship (T)		1				, City or Town, State, Z	
e, N 1 and Health Am 27	1	TED RUBINSTEIN /	20b. F	Place of Dispo	sition (Name of	1		N, MD 21136 20c. Location - City or 1	
MOT Pages ent of nt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	removal from State		HEBREW (1		BALTIMOF	
Baltimore, permit. Pages 1a Depertment of Her Important: If item any injury or othe		21. Signature of unera Service Uorns	111					ON & BROS.,	
o 82558		Munaux 2	nuger	8	<u>900 REIST</u>	ERSTOWN	ROAD - P	IKESVILLE,	MD 21208
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cadse on each line.	2	59			est,	Approximate Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	a Due to (or as a conseq	entr	cular	Arryt	hmia		
Examiner		Sequentially list conditions,	Cor	onar	y Arte	ery Dis	ease		
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o, c	Exar	that initiated events resulting in death) Last	Due to (or as a conseq		es me	THE			
58760, <	dlcal		d						
	~	IF FEMALE;	23c. If yes, outcome of pregna	ancv				201.0	
IS, P.O. BOX 6 res that the death certific igned by the attending p be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of c	ildeath 3□	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date of deli Month	Day Year
by the	hysl	9 Unknown	9□ Unknown						
S, F	by P	Part II. Other significant conditions co				en in Part I.		pacco use contribute to	
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Rec he lav e has age 2 a	Completed						24a. Was a autops perform	med? prior to death?	topsy findings available ompletion of cause of
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of V hysic his ce at direc	To B	1 5 63 2 10	Hospital: 1 Inpatient 2			4 Nursing r	Home 5 ☐ Reside	ence 6 Other (Spec	ufy)
ding P		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ⊡ No	28d. Describe ho	ow injury occurred	
Division attand after death I Diractor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury At h	ome, farm, sti				reet and Number or Ru	ral Route Number,
Divinite or a safe or a la Divinite or a la Divinite or a la Divinite or a la l	Cert	4 Homicide	building, etc. (Special	y) 			City or Town	n, State)	
Hosp 24 hou Funer	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sicien: To the best of my kno iner: On the basis of examina	owledge, deat ation and/or in	n occurred at the till vestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
Division of Vital Records, P.O. Box (To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Mec	29b. Signature and tiple of certifier	and manner stated.		29c. Licens	e number	25	9d. Date signed (Monti	, Day, Year)
->-0		1 Cfatra	Mars	-M.C	, Doc	5448	٤	February	13,2006
2		30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type,	Print\				
,	te	Patrick M. Ginley 31. Date filed (Month, Day, Year)	Registrar's Signa		elredera	AUR 1	Jaltimor	e, mu 2	1413

Registrar

FEB 1 7 2006 Robert & Aprile

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:054 FEB ANDREW SOCHA 300 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Multi-Medical Nursing Home Towson 8. Date of Birth (Month, Day, Year) NOV . 24, 1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. 1**⊠** M 2□ F Months Days Hours MAryland 215-30-6154 72 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Woolcal Examiner must be notified at 1 ☐ Yes 2X No MD Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2 Pinyon Court 21220 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. YSYes 2 □ No If Yes, Give 1 Never Married 2000 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic avent. If a Multipone. Post Office College (1-4or 5+) Elementary/Secondary (0-12) Mail Carrier 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Socha Elorna Machuck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Pinyon Court Baltimore MD 21220

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith 2/16/06

Baltimore Lorraine Socha /wife 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signaty of Funeral Service Licensee Ave. Baltimore MD 300 Mace 23a. Part1. Enter the disease, or complications that caused the death. For not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List employee cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE RENAL DISEABE **Physician** moneta /Medical Due to (or as a consequence of): CORONARY ARTERY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Onknown leted 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

executed Box 68760 99 P.O. Division of Vital Records, Hospital or Attanding Pl
 A hours after death.
 Funaral Diractor: After ti 24 hours a To the within 2

Baltimore, Maryland 21215-0036

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

SHAWNNACA 31. Date filed (Month, Day, Year) 7 2006



and manner stated.

Spepte MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0053150

29d. Date signed (Month, Day, Year)

FEB 1490 2006

Registrar DHMH 17 Rev 1/2001

State

5+1

29b. Signature and title of certification

31. Date filed (Month, Day, Year)

JACK

FEB 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

My Wil).

2. Registrar's Signature

2218

29c. License number

OCME

29d. Date signed (Month, Day, Year)

111 Penn Street Baltimore, Maryland 21201

<u>February 15, 2006</u>

			1 - For State Registrar	te of Maryland / Do		of Health and of Death		giene) () (5	04721
	BA FA	ė 9	Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
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	Examin		4a. Facility Name (If not institution, give street as	nd number)	4b. City, T	own, or Location of Deal	ħ	4c. County of Deatl	1
			Manor Care Ruxton			owson		Baltimo	re Co.
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 20	3. Age (In yrs. last birth	Months	1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day March 4	(Year) Co.	nplace (State or Foreign untry) ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	f sho	ō				Engtro	- 4		1 ☐ Yes ※XNo
	28a-	Director	Maryland Baltimor	e L	10f. Zip (Eastwo Code		log. Citizen of What Co	untry?
	3a ol		6924 Eastbrook Ave	nue		21224		United St	ates
	death me 2	ner	11. Marital Status 12. Was	Decedent Ever in U.S.	13. Was Decede	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
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9	2 hou	Completed	15. Decedent's Education		Decedent's Usual		diag	16b. Kind of Business/l	ndustry
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Maryland 21215-0036	d be fill ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Stanislaus Grabeck	i			me <i>(First, Middle, :</i> a Kendrze		
Ž	should of Me mark matic	2	19a. Informant's Name/Relationship (Type, Prin		Mailing Address	(Street and Number or R		-	in Code)
, Ma	and 2 sealth an m 27 is		Patricia M. Fischer (D	aughter) 1	4303 Da	irydale Roa	d Baldw:	in, MD 210	13
Baltimore,	Pages 1 ent of H nt: If Ite ry or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery,	Disposition (Name crematory or oth canislau	e of her place) s Cemetery		20c. Location - City or Balto,	Town, State Maryland
alti	mit. partm sorta / inju		21. Signatur , of Funeral Service Licensee	00		Address of Facility al			nc.
m	Department		deregon E.	Kun		ise Ave. D			1222
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	he Ho in 24 t he Fu pletely	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/ manner stated.	or investigation, i	in my opinion, death occi	urred at the time, d	late and place, and due	to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	150		License number	2	29d. Date signed (Month $2 - 13 - 6$	n, Day, Year)
,	,	1	30. Name and address of person who completes	f cause of death (Hom 22-) /T		005442			
	<u>ó</u>	4	Cyrus Asadi 206		n rol.	suite #209	Timonic	im, MD 2	4093
L.	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 2006	32. Registrar's Signature	List !				

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		-	State Registrar		Certificate	e of Death	Reg. 7	16. UU0	04166
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		- (* - (*)	5. Social Security Number 6. Sex	7. Age (In yrs. last		0001	8. Date of Birth		nplace (State or Foreign
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e, M	other t		Mr. Lawrence G. Spedde				Rosedale, N		
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8	or u	lan	in the past 12 months?	ive birth 2 Tetal dea	ath 3 □Ectopic pr			23d. Date of delive Month	very Day Year
0 8	hed	Sic		regnant at time ot death Inknown	n 5 ☐ Other (sp	00C(TY)			
Division of Vital Records, P.O. to Attending Physician: The law requires that the dates death.	d by	Physician/Medi	Part II. Other significant conditions contributing	to death but not reculting	a in the underlying o	auca gwen in Part I	23e Did tobacc	o use confribute to	the cause of death?
<u>v</u> 8	p eq	ğ	tichetec N	DP111+125	g in the dilderlying c	ause given in Fait I.	1 ☐ Yes	: /	bably 4 Unknown
orc.	pinos	Completed	Plane 1) = 1 +			1 103	2000 30110	- Onknown
aw G	2 sh	be	End Stage 1	enal 1	Diseas	se	24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
E E	ate h	E O					performed 1 ☐ Yes 2 🖸	death?	2 □ No
ta an:	tor. p	0	25. Was case referred to medical	i .		26. Place of Dea	th (Check only one)		
ysic	direc	ToB	examiner? N☑ Yes 2 No Hospital:	1 Inpatient 2 □ ER/	Outpatient 3 DC	OA Other: 4 Nursing H	ome 5 🗆 Residence	6 ☐Other (Spec	afy)
0 4	er th		27. Man er of Death 28a. I	Date of Injury 28t	b. Time of 2	8c. Injury at Work?	28d. Describe how in	jury occurred	
O HE E	tru atru	뜵	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	Month, Day 19al)	Injury M	1 ☐ Yes 2 ☐ No			
/iSi	y the	i Ca	3 Suicide 6 Could not be 28e.	Place of Injury - At home,	, farm, street, factor	y, office	28f. Location (Street	and Number or Rui	rai Route Number,
Div.	d in	Certification:	4 Homicide determined	ouilding, etc. (Specity)			City or Town, Sta	1(0)	
spits	filler filler		29a. Certifier 1X Certifying Physician: T	o the best of my knowled	dge, death occurred	at the time, date and place,	, and due to the cause	(s) and manner as	stated.
9 Ho	e Fu	Medicai	(Check only 2 Medical Examiner: On	he basis of examination manner stated.	and/or investigation	, in my opinion, death occur	rred at the time, date a	and place, and due	to the cause(s)
Division of Vital Records, P.O. Box 68760, < To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	omp	Me	29b. Signature and title of certifier	7 ×	290	c. License number	29d. [Date signed (Month	, Day, Year)
F 31	- 0		1.0,449	Co		H005599	2	02/11/0	0(0
			30. Name and address of person who completed	cause of death (Item CC	a) (Tuno Brist)				
1	$0 \parallel$		Debuvan Gallo	Del Coatti (Item 23	730 H	kbird A	12/1	home 1	10 2007
	Stat	10		32. Registrar's Signature			- Lui		1000
	اعاد Registra		EER 1 7 2006	Andrew 18	Speak!				

			1 - For State Registrar		f Maryland	/ Depa		t of H	ealth a		ental Hyg	iene	6	01.723
			Decedent's Name (First, Middle)	dle, Last)			rimouri				2. Date of Deat			3. Time of Death
	Physic √Medi		ALBERT	5717	2_						Month FEB 1	Day Zan Za	Year	10=25A M
	Exami		4a. Facility Name (If not institution		mber)		4b. City,	Town, or	Location o	of Death		4c. Count	of Deat	th
			Multi Medical	Center			To	wsor						Baltimore
	Funeral Director		5. Social Security Number 213-05-0991 Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan. 3	Year) 1 ,1 915		hplace (State or Foreign buntry) ryland
	land ow		10a. State 10b. Count	у	10c. City, T	own or Lo	ocation							10d. Inside City Limits
	72 hours after death with the Maryland 'neturel', or Items 23e or 28a-f show digal Examinal must be notified at	Funeral Director	Maryland 10e. Street and Number	Baltimore			10f. Zip	Code		Dund		Og. Citizen of	What Co	1 ☐ Yes 2 ☒ No
	3e or	ā	3432 Yorkwa	V					212	222		Unite		•
	death	nerg	11. Marital Status		edent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			nican Indian,
21215-0036	ours after rel', or Ite Examina	b	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1X Yes	2 No /e		il Yes, spec		Specify:	, Puerto i	rican, etc.)	Specif.	ck, Whit y:	e, etc. White
2-0	72 hc	Completed	15. Decede (Specify only high	int's Education est grade completed)	1	6a. Dece	dent's Usua kind of wor	l Occupa	ition furing most	of working	ng	6b. Kind of B	usiness/	Industry
121	d within 72 ho piene. r then "netu	dmo	Elementary/Secondary (0-12)		-4or 5+)		kind of wor DO NOT us					Mana	faat	uring
d 2	Hyg Hyg		17. Father's Name (First, Middle	a, Last)		Mc	achine	ope			(First, Middle, N			uring
Maryland		To Be	William Stit	z							e Dieker			
ary	S D E E	-	19a. Informant's Name/Relation	ship (Type, Print)	(Son)	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or Town,	State, 2	Zip Code)
	and 2 palith a n 27 le er trai		Mr. Albert R.	Stitz, Jr		1898	Augu	st A	venue	e Di	ındalk,	Maryla	nd	21222
ore	es 1 and of Healt f item 2 r other		20a. Method of Disposition 15 Burial 2 Cremation	3 Permayal from	0000	e of Dispo	sition (Nam natory or ot	e of her place	9)	D	ate 2	Oc. Location	City or	Town, State
<u>Ĕ</u>	Pages ment of I		`4 □ Donation 5 □ Other (Specify)		y Hi	ll Me	m. G	dns.	2/17	/2006	Middle	e Ri	ver, MD
Baltimore,	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Services	Licensee	and a			Ruck	Fune	eral	Home of			Inc. 21222
13	Prysician		23a. Parti. Enter the disease, c shock, or hear failure. Lie Immediate Cause (Final disease or condition			Oo not ent	er the mode	of dying	, such as	cardiac o				Approximate Interval Between Onset and Death
i.	/Medical		resulting in death)	aDue to (or as a consequen	ce of):	Or	,, .	/					monetis
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	DEME		1,1							nonlin
	tad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	-	0011	11		- /				monety
,	ate be executad hysician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequen		10 CG	14	vere	MC	4			· · · · · · · · · · · · · · · · · · ·
8760,	e be (siciar	cal		d										
.89	tificat ig phy as the	b												
P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come of pregnancy irth 2 Fetal dea ant at time of death own	ath 3□	Ectopic pre Other (spe						te of deli nth	very Day Year
Records, P.	w requires that the de been signad by the should be detachad	by	Part II. Other significant condition	ions contributing to de	eath but not resultin	g in the un	nderlying ca	use give	n in Part I.					the cause of death?
000	aw rei	plete									24a. Was an			topsy findings available
		Completed									autopsy perform 1 Yes 2	ed?	death?	ompletion of cause of 2 No
of Vital	Attending Physicien: Th r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medica examiner?	Hospital:							Check on , one			
o	Phys this ral dir	. To	1 Yes 2 No 27. Manney of Death	1 4		Outpatien D. Time of	t 3 DO	lc. Injury	Nur		e 5 Resider			rify)
O	ding h. After fune	tlon	1. Natural 5 ☐ Pendi	ng (Monti	of Injury h, Day Year) 28t	Injury	M	Work'			8d. Describe how	v injury occurr	90	
	To the Hospital or Attending Physicien: To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At home, ng, etc. (Specify)	, farm, stre	et, factory,			-	8f. Location (Stre City or Town,	et and Numb State)	er or Ru	ral Route Number,
	spital ours al		29a, Certifier	ng Physician: To the	best of my knowler	ine death	occurred a	t the time	date and	I place, as	nd due to the car	so(s) and ma		etatod
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	one)	and mann	isis of examination	and/or inv	estigation, i	in my opi	nion, death	n occurre	d at the time, dat	e and place,	and due	to the cause(s)
	To To Com	2	29b. Signature and title of certifie)		29c.	License	number		29	d. Date signed	(Month	, Day, Year)
	, 1			pte MS			T	000	055	120	F	28 14	un E	1006
51	7	ļ	30. Name and address of person	e ACA	GUP74	a) (Type, I	Print) 7650	5 SA	271	A20	o ROA	20 0	50,	100 6 11 = 110 14 BIA 2045
	Sta		31. Date filed (Month, Day, Year,	32.4Re	egistrar's Signature	Land	will!							4095
	Registr	ar	FEB 1	7 2006	exe so	17	2000000							

		For	State of Marylan					-		•		
		1 - For State Registrar		Ce	rtificate	of D	eath		Reg. No	2006	04721	1
Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Da	y Year	3. Time of Death	
/Med		Walter Gregory						FEB.	15			М
Exami	ner	4a. Facility Name (If not institution, give s					ocation of Deat	h	40	. County of Dea		
Europa	7	Good Samaritan Ho		last birthday)	If Under 1	Year	imore If Under 24 Hrs	8. Date of B	irth	N/A 9. Bi	thplace (State or Forei	ign
Funeral Director	_		[M 2□F 79	Yrs.	Months	Days	Hours Min.	8. Date of B (Month, D Nov. 1	5, Year)	926	Maryland	
g ,		Usual Residence of Decedent 10a, State 10b, County	100 Cit	v. Town or Lo	neation.						10d. Inside City Limi	its
shov	7		Toc. Cit	y, 10w11 07 L		0.4.4					1 Yes 2 □ N	
the N	ect	Maryland N/A 10e. Street and Number			10f. Zip C	utin	nore		10g. Cit	tizen of What C	ountry?	_
at y failed A IA I COOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	Funeral Director	3216 Brendan Avenu	10			21	213			u.s.	Α.	
death	nera		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decede			Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Whi	erican Indian,	_
or he after	y Fu	1 Never Married 2 Married	1 Yes 2 No		1 ☐ Yes 2		Specify:	,		Specific		
hours ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates: 194		dent's Usual		ion		16h K	and of Business	White	
in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work DO NOT use	done du	ring most of wo	rking	100, 10	and of business	undustry	
3 with giene.	mo	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		Cl	erk				Wareh	ouse	
a file al Hyg othe	Be C	17. Father's Name (First, Middle, Last)						me (First, Middle		Sumame)		
Menta Menta arked	10	George Smith						vrie Tur				
2 sho		19a. Informant's Name/Relationship (Type						ural Route Num				
C, IV		John Smith (Brothe	ン <u>た</u>) 20b. F	lace of Disp	7 Deer osition (Name matory or oth	ing	Road, F	<u>Pasadena</u> Date	. Ma	ryland ocation - City o	21122 r Town, State	_
Pagas 1 hent of H not: If itan		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	_				8/2006				
permit. Departrimporta		Y Trans	20/					Baltimo				
		23a Part1. Enter the disease, or compli shock, or heart failure. List only of	cations that caused the deat	h. Do not en	ter the mode	of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	SEPS	515				DOMINA		BSCESS	Onset and Death	
/Medical		resulting in death)	Due to (or as a conseq									
Examine		Sequentially list conditions,	Due to (or as a conseq		ANCE							_
ted ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	derice or).								
be axecuted ician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
te be ax ysician	cail		l									
w requires that the death certificate be axecuted been signed by the attending physician and should be detached for use as the burial-transit	-	IE EENAALE.										
th ce tendii	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[⊒Ectopic pre					23d. Date of de Month	olivery Day Year	
the at	/sici	1 Yes 2 No	4□Pregnanf at time of d 9□Unknown	eath 5[Other (spe	cify)						
that that that the		Part II. Difher significent conditions con	ntributing to death but not res	ulting in the u	underlying car	use giver	n in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
requiras l	d by	CORONARY AR	TERY DISEAS	E				1 🗆	Yes 2	□No 3□F	Probably 4 Unknow	Ν'n
w req	Completed							24a. Wa		24b. Were a	utopsy findings availal	ple
The la te has age 2	omp							aut per 1 ☐ Yes	opsy formed? 2 Z No	death?		JΪ
stori of vital may tending Physician: The lav Seath. tor: After this certificate has the funeral director, page 2	O	25. Was case referred to medical					26. Place of De	ath (Check only				
Physical this ce	To B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 ⊠1npatient 2 □	ER/Outpatie	nt 3 DOA		4 Ivuising	Home 5 Res			ecify)	
ding Pl	on:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		lc. Injury Work		28d. Describe	how inju	ry occurred		
Seath.	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm of	M Irack factors		es 2 No	28f Location	(Street a	nd Number or F	Rural Route Number,	
or All	ertification:	4 Homicide determined	building, etc. (Specif	y)	леег, гастогу,	OHICH			own, State		in a riodic rearison,	
spital rours neral	O	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, dea	th occurred a	t the time	e, date and place	e, and due to th	e cause(s) and manner a	is stated.	
To the Hospital or Attending Physician: The law requiras that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signad by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edicai	one)	ner: On the basis of examina and manner stated.	ition and/or in				urred at the time				
To t comp	Σ	29b. Signature and title of certifier NIPSh Par	on 1st			License				ite signed (Mor	-	
						r 7			FET	3. 16	, 2006	
5		30. Name and address of person who co	empleted cause of death (Item 560)	n 23a) (Type LO(, Print) H RAV	EN	BOULE	VARD,	BALT	more,	MP 21239	
9	taté	31. Date filed (Month, Day, Year)	32. Registrar's Signa		A 200	_		7				
Reais		FFD 1 7 21	nne &	4 6	Sach !							

		ļ	1 - For S Ragistrar	tate of Ma	ryland /	-	artment tificate			nd M	ental Hygi	ene	6	0472	25
			1. Decedent's Name (First, Middle, Last)								2. Date of Death		Voor	3. Time of	Death
	Physicia /Medic		Robert Henry Szech,	Jr.							Februar	y 12, 2	2006	6:45	а м
	Examin		4a. Facility Name (If not institution, give street	at and number)					Location o	f Death		4c. County			
			Lorien @ Riverside				If Under	elca		14 Uro		Hari			
Г	Funeral Director		5. Social Security Number 6. Sex 1 M		(In yrs. last	Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, May 23,	Year)	9. Birthp Cour Mar	lace (State o try) yland	r Foreign
			Usual Residence of Decedent))1							11ay 25;	1711	11111	<i>y</i> 20110	
	ylanc		10a. State 10b. County		10c. City, To								1	0d. Inside Cit	
	B Mai	ctor	Md. Harford			гал	1ston							1 Tes	2 🗗 No
	or 28	by Funeral Director	10e. Street and Number				10f. Zip				10	g. Citizen of V		ntry?	
	s 23e	ra	2109 Haverbrook Dri		and the second	40.1		1047		i-0 /C	- H. Van as bla	U.S.A.		an Indian,	
	ltern Item	nne	T. Maria. States	Was Decedent E Armed Forces? I ∐Yes 2⊠No		13. V	Yes, spec	ent of Hi	n, Mexican	m? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Blac	k, White,	etc.	
990	urs af	by		f Yes, Give Year or Dates:		1	I□Yes 2	® No	Specify:			Specify	whi	te	
Ö	72 ho	Completed	15. Decedent's Education (Specify only highest grade co	on moleted)	16	6a. Deced	lent's Usua	l Occupa	ation furing most	of warki	na 1	6b. Kind of Bu	siness/In	dustry	
2	ithin Jen M	nple		College (1-4or 5+		life. L	DO NOT us	e retired)	0, 1101111			. 1		
2	iled w fygier her ti nt, in		8 years 17. Father's Name (First, Middle, Last)			olann	er		18 Mothe	r's Name	(First, Middle, M	tin mi			
anc	ontal H ed of	Be C	Robert H. Szech, Si								allon	adon ouman	.0)		
Maryland 21215-0036	should nd Me mark imeti	^L	19a. Informant's Name/Relationship (Type,		1	19b. Mailin	g Address	(Street a			I Route Number,	City or Town,	State, Zip	Code)	
S	alth ar 27 is rr treu		Cyrile Sincock/daug	hter	3	304 C	ass C	t.,	Bel A	Air,	Md. 210	15			
Jre,	ss 1 a		20a. Method of Disposition 1 Burial 2 Cremation 3 Remo		20b. Place ceme	e of Dispo	sition (Nan	ne of ther place	θ)	- 0	ate 2	Oc. Location -			
<u><u>E</u></u>	Page nent o		*4 □ Donation 5 □ Other (Specify)	oval from State	Dular	ney V	alley	Men	n. Gdr	ns.	2/15/200	6 Timon	nium,	Md.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show ery injury or other treumetic event, Ite Madical Examitier must be milling at once.		21. Signature of Funeral Service Cloensee			22 S	. Name an	d Addres inek	s of Facility Fune	ral 1	Home of	Bel Ai:	r, In	ıc.	
	70 E 9 9		Den 2 Jeun			6	10 W.	Mac	Phai	L Ro	ad, Bel	Air, Mo		014	
Ц			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications of the complete state of the complete state.	ons that caused t ause on each line	the death. D	o not enti	er the mode	e of dylne	g, such as	cardiac c	or respiratory arre	SI,		Approximate Interval Bette Onset and I	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pneum									F	'ew day	7S
	Examiner		ſ	Due to (or as a	consequen	ce of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of):									
8	cuted nd ransit	Examiner	that initiated events												
Ö,	e exe ian a urial-1	I Ex	resulting in death) Last	Due to (or as a	consequen	ce of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d												
9 XO	eath certific attending pi	Physician/Med	IF FEMALE: 23c.	f yes, outcome o	of pregnancy	,						23d Da	e of delive	an/	
\mathbf{m}	atten atten I for u	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	2 ☐ Fetal dea	ath 3	Ectopic pro					Mo		•	Year
o.	that the de ned by the a detached t	hysi	9 Unknown	9□ Unknown											
ď.	es thai igned t be det	by P	Part II. Other significant conditions contrib	uting to death but	t not resultin	ng in the ur	nderlying ca	ause give	an in Part I.		23e. Did tob	acco use cont	ribute to th	ne cause of d	leath?
ğ	w require been sig should b	led	Failure to thrive								1 🗆 Yes	s 2√	3 🗆 Prob	ably 4 🗆	Jnknown
Records,	lawr las be 12 sh	Completed									24a. Was an autopsy	/ 1	orior to co	psy findings mpletion of c	available ause of
<u>~</u>	Physicien: The lav this certificate has al director, page 2	Con									perform 1 Tes 2		death?	2□No	
Vita	Physicien: rthis certifica ral director, p	Be	25. Was case referred to medical examiner?	ital:				Othe			(Check only one	11.		-	
ō		. To	I L Yes 2⊠ No	1 ☐ Inpatien 8a. Date of Injury (Month, Day		Outpatien b. Time of		Bc. Injury Work			me 5 Resider 28d. Describe hov			у)	
0	Attending F r death. ector: After by the funer	atlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		k? Yes 2.⊟1	No					
Division of Vital	l or Attendater death Director: In by the	Certification:	a Could not be	8e. Place of Injur	ry - At home	, farm, str	eet, factory	, office			28f. Location (Str. City or Town,		er or Rura	I Route Num	iber,
Ö	itel or irs afte rel Dir led in														
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only const. Certifying Physicial Certifying Phys	On the basis of e	examination										;)
	o the ithin 2 o the xmplet	Med	one) 29b. Signature and title of certifier	and manner state	iea.		290	. License	number		29	9d. Date signe	d (Month,	Day, Year)	
	E W T OS		• / /)1958							1001
	()		30. Name and address of person who compl	eted cause of de	ath (Item 23	Ba) (Type		-175			 †	ebruc	WY	12,0	006
	P		Manuel M. Lazatin,					leen	, Md.	210			/		
	Sta		31. Date filed (Month, Day, Year) FEB 1 7 200	32. Filistrai	r's Signature			D							
	Registr	ar	LEBI 1 200	O States	ور منه	A									

			For	ase Type or State of		nd / Depa	artment (of H	ealth and I			-	04726	
		-	State Registrar Decedent's Name (First, Middentification)	fle, Last)		Cei	rtificate	Of L	Jeath	2. Date of D	Reg. No.		3. Time of Death	
	Physici /Medi		Anthony Shemor	nski						Feb.	14 ^{Day}	2008	5:00 P. M	
	Examir		4a. Facility Name (If not institution		ımber)				Location of Death			County of De		
	Funeral		Stella Maris F 5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	Timon:	Year	If Under 24 Hrs.	8. Date of B	irth		County irthplace (State or Foreign	
	Director		061-14-5297 Usual Residence of Decedent	1 □XM 2 □ F	90	Yrs.	Months [Days	Hours Min.	June 2			est Virginia	
	how how		10a. State 10b. Count	•	1	City, Town or Lo							10d. Inside City Limits	
	8a-fs	Director		imore Coun	ty I	Parkton							1 ☐ Yes 2 No	
	Mith t	DI	10e. Street and Number 1509 Harris Mi	ill Road			10f. Zip Ci				_	izen of What (ted Sta		
	death	nera	11. Marital Status		edent Ever in	U.S. 13.			spanic Origin? (S n, Mexican, Puert	pecify Yes or N			nerican Indian,	
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 TYes	2 □ No ive		1 ☐ Yes 2 ☐		Specify:	Thouse, etc.,		Specify: Wh		
21215-0036	72 hc "natur	eted	15. Decede (Specify only high	nt's Education est grade completed,)	(Give	dent's Usual (done a	turing most of wor.	king	16b. Ki	ind of Busines	s/Industry	
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p	al Hyg al Hyg sother	BeC	17. Father's Name (First, Middle	, Last)	./	i nacii	111100		18. Mother's Nam		e, Maiden	Sumame)		
Maryland	Ment Ment Marked Marked	10	Michael Shemor						Mary Hl					
, Ma	and 2 st eith and 127 is n ar traun		19a. Informant's Name/Relation Mrs. Anne Shemo		fe)		-		ind Number or Ru ill Road		-			
Baltimore,	eges 1 int of He t: If Item 7 or oth				State	cemetery, crei	matory or othe	of er place		Date 2006				
altin	mit. P pertme portani y Injury		1 Burial 2 Occumation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Page 11 Alternatives Fineral & Cremation Ctr.											
8	Depermine Depe		20a. Method of Disposition 1 Burial 2 Toremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Chapel 20c. Location - City or Torematory or other place) Feb. 16, 2006 Forest Hill											
	Medical /Medical Examiner	Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	a PRO	each line. STATE (or as a conse	equence of):							Interval Between Onset and Death	
). Box 68760,	death certificate be e attending physicie d for use as the bur	Physician/Medical Exa	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d. 23c. If yes, ou 1 □ Live	(or as a consecution of pregration of pregration of pregration of pregration of pregration of the program of t	nancy tel death 3[⊒Ectopic preg ⊒ Other (spec			_		23d. Date of d Month	lelivery Day Year	
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V.	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Innatient 2	☐ ER/Outpatier	nt 3 DOA	Othe	26. Place of Dea			s W Other (Se	oecify) HOSPICE	
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Ö	To the Hospital or within 24 hours efte To the Funeral Director completely filled in the Funeral Director of the Funeral Direc	edical Cert	29a. Certifier 1 X Certify	ing Physician: To th	e best of my kroasis of examinated.	nowledge, deat	h occurred at vestigation, in	the tim	ne, date and place binion, death occu	and due to the	e cause(s)	and manner	as stated. ue to the cause(s)	
	To the Within To the	Me	29b. Signature and title of certific				29c. L	icense	number		29d. Dat	te signed (Mo	nth, Day, Year)	
,	A		20 Name and addiscrete	a who completed :	no of death for	22-\ /T	1	المار	3725			2/15/	06	
1	Vol		30. Name and address of person DR. TARIO MA	HMOOD 230	OO DIIT.A	NEY VAT	LEY RD).	TIMONIUM	[, MD 2	1093	121		
	Sta Registi		31. Date filed (Month, Day, Year		Registrar's Sign	nature	Soil	S S S S S S S S S S S S S S S S S S S		- <u> </u>				
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Q 2.	Discosio)		1. Decedent's Name (First, Middle, Last,)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Louanne Burleic								Februar	v 9 20	106	9:10 a M
-	Examin	er	4a. Facility Name (If not institution, give	street and numb	er)				ocation of			4c. County		
1			30 Boone Trail 5. Social Security Number 6. Securit	7	Age (In yrs. i	last hirthday)	Sev If Under		Park If Under 2		8 Date of Birth	Anne		ndel place (State or Foreign
	Funeral Director			м ж т		7 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day		Cou	ntry)
- 100			Usual Residence of Decedent								July 24	1918		7
	arylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	8a-f	ecto	MD Anne Ar	undel	Sev	erna P								1 ☐ Yes 2 X No
	with ti	Funeral Director	10e. Street and Number 30 Boone Trail				10f. Zip	146			1	0g. Citizen of W	/hat Cou SA	ntry?
	ns 23	erai	11. Marital Status	12. Was Decede	ant Ever in U	S. 13.V			nanic Origi	in? (Spe	cify Yes or No-			can Indian,
(0	r Iten	표	1 ☐ Never Married 2 ☐ Married	Armed Force	s?	1	f Yes, spec	fy Cuban	, Mexican,	Puerto	Rican, etc.)	Blac	k, White	etc.
ğ	ral', c	i by	35☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	os:		¹□Yes 2	X_J No	Specify: \	WIITL	.e	Specify	: WI.	ilte
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7	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Homema	00 NOTus aker	a ratirad)				Home		
0	Hygi Hygi other		17. Father's Name (First, Middle, Last)			110 mcm			18. Mother	's Name	(First, Middle,		e)	
an	fental fental rked ric ev	To Be	Louis James Burle	igh					Anne	tte	Mettam			
Baitimore, Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f ehow or other traumatic evant, the Medical Evarinar must be nuffled at		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Address	(Street ar	nd Number	or Rura	l Route Number	r, City or Town,	State, Zi	Code)
Z,	and seatth m 27		Phoebe Schwarz	- Daught					L. Se		a Park,			
Ore	it of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from Sta		lace of Dispo energy crem Ion Par) @ L	_		20c. Location -	,	
量	it. Partimer ritent		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lious	00	Loud						13, 06 don Par			
Ba	permit. Pages 1 and 2 Department of Heatth a Important: If item 27 Is any injury or other tra ance.		Kim A	black	10011						altimor			
			23a. Part . Enter the disease, or compl shock, or heart failure. List only or	ications that cau	sed the death	n. Do not ent	er the mode	of dying	, such as c	ardiac o	r respiratory arr	est,		Approximate Interval Between
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	/Medical		resulting in death)		as a consequ									-·
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8760,	icate be executed physician and s the burial-transit	dical		d										
9		Med	IF FEMALE:											
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal	death 3	Ectopic pre					23d. Date Mor		ery Day Year
<u>.</u>	he de the a	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of de	eath 5∟	Other (spe	ecify)						
Ω.	es that the death certifi igned by the attending I be detached for use as	y Ph	Part II. Other significant conditions con	ntributing to deat	h but not resu	ulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to	bacco use contr	ibute to	he cause of death?
rds	quires n sign	ed by									1 🗆 Y	es 2 2 10 0	3 ☐ Pro	bably 4 □Unknown
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uo.	ding l h. After funer	tlon	1 Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury	M Z	Sc. Injury Work?	at Ps 2.∏N		28d. Describe h	ow injury occurre	90	
Division of Vital Records,	f or Attending after death. Director: After I in by the funer	ifica	3 Suicide 6 Could not be	28e. Place of	Injury - At ho	me, farm, str				-	28f. Location (S	treet and Numbe	er or Rur	al Route Number,
٥	s after al Direct	Certification:	4 Homicide determined	building.	, etc. (Specify	′)					City or Town	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 15 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basi	s of examinat	wledge, death tion and/or inv	occurred a	it the time	, date and nion, death	place, a	and due to the c ed at the time, d	ause(s) and ma ate and place, a	nner as : ind due t	stated. o the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner	stated.		29c.	License	number		2	9d. Date signed	(Month,	Day, Year)
)	⊢ s ⊢ ō) would	M			1)2	476	8		2-9	-04	
	5		30. Name and address of person who co		of death (Item		Print)	101	∧ -∧	0 0	210	, 2w	111	ams
17	Sta	te.	31. Date filed (Month, Day, Year)		Střar's Signa	RD,	HKM	J UL	ا ر	שויי	010	, 0-	1	Ju 🔾 -
*	Registr		EFR 1 7 21	1	20,000	M. A	back.	p						

	•	For State Registrar	State of N	/larylan		artmen rtificat			ınd Mei		giene Reg. No	-000	04728
		Decedent's Name (First, Middle, La	ast)						2.	Date of Dea	ath		3. Time of Death
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Examin		4a. Facility Name (If not institution, gir			j		Town, or	Location o	Death		4c.	. County of Deal	h
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Funeral		,		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours		Date of Birt (Month, Day	h y, Year)	9. Birt	hplace (State or Foreign
Director		N/A	1XM 2□F	0	Yrs.	0	1			b. 12		006 Mary	
pu s		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation		-					10d. Inside City Limits
anyla	ă												1 ☐ Yes 2 ☑ No
1he N	Director	Maryland Charles 10e. Street and Number		Whi	te Pla	101. Zip	Codo	_			10a Cit	tizen of What Co	unatar?
o or		PO Box 1323						-					ond y :
hours after death with the Maryland turer, or iteme 23e or 28a-f show at Exerciter must be notified at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	S. 13	_	20695 dent of Hi		nin? (Specify	Yes or No	US	14. Race - Ame	nican Indian.
fig. 16	ᇤ	1 ☑ Never Married 2 ☐ Married	Armed Force	s?		If Yes, spec	offy Cuba	n, Mexican	, Puerto Ric	y Yes or No- an, etc.)		Black, Whit	
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2 ho	Completed	15. Decedent's E			16a. Dece	dent's Usua	al Occupa	ation	-6		16b. K	and of Business	Industry
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al Hy	Be	17. Father's Name (First, Middle, Las	t)							irst, Middle,	Maiden	Sumame)	
Ment	ဥ	Wayne M	ichael	5	Swann			Tar	nmy		Sue		Duker
and and		19a. Informant's Name/Relationship			1	•						or Town, State,	Zip Code)
and and m 27		Wayne M. Swann (Father)	1				white		s, MD			
of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from Sta	20b. F	Place of Disponent Council Loud Council Counci	natory or c	ne of ther place	e)	Date	·	20c. L	ocation - City or	Town, State
Pag men ment: lury		4 □Donation 5 □ Other (Spec		Day					2/16/0				Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Department of Health and Mental Hygiene frie fireportent: if I tem 27 is marked other than "natural", eny injury or other treumatic event, the Medical Eve once.		21. Signature of Funeral Service Lice	ansee.									Funeral	
20 E 0 0												, MD 212	
		23a. Part f. Enter the disease, or cor shock, or heart failure. List onh	nplications that caus y one cause on each	ed the deat line.	h. Do not ent	er the mod	le of dying	g, such as	cardiac or re	spiratory ar	rrest,		Approximate Interval Between Onset and Death
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eath etten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant	2 Feta	I death 3	Ectopic pr						Month Month	Day Year
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n: T ficete or, pa	ပိ	OF Was some referred to medical							15 11 16		2 No	1 ☐ Yes	2□ No
sicia certi	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	stiont 2	LEB/Outpotion		Othe	25		heck only o		6 □Other (Spe	- 4.1
Phy ratid	٠. ٦	27. Manner of Death	28a. Date of la (Month, I		ER/Outpatier 28b. Time o		28c. Injury Work	4 🗀 140		Describe I			city)
ding th.	Ę.	1/ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		<br Yes 2 □ l	No				
Atter dea	ertification;	3 ☐ Suicide 6 ☐ Could not	289. Place of	Injury - At h	ome, farm, st	reet, factory	, office		28f				ural Route Number,
afte Dir d in b	ert	4 Homicide	building,	etc. (Specif	(y)					City or Tov	vn, State	9)	
spita hours nere y fille	alc	29a. Certifier 1 Certifying P	hysician: To the be	st of my kno	wledge, deat	h occurred	at the tim	ne, date an	d place, and	due to the	cause(s) and manner a	s stated.
ne Ho n 24 l ne Fu	edical	(Check only 2 Medical Exa	iminer: On the basis and manner	of examina	ition and/or in	vestigation	, in my op	pinion, deal	th occurred	at the time,	date an	d place, and due	to the cause(s)
To the Hospital or Attending Physician: The law requires thet the death certific within 24 hours after decidence within 24 hours after decidence. The the Funce of Director: After this certificate has been signed by the ettending prompletely filled in by the funeral director, page 2 should be detached for use as	×	29b. Signature and title of certifier					. License					ate signed (Mont	
		7	- KAN L	CHAU	= 2 CAN	N.C.	RE	5.00	00	1	-Ebi	RUARU 1	5,2006
4		30. Name and address of person who			п 23а) (Туре,	Print)			~, A			1	
1		RAUL CHAVEZ	VALDEZ	140	100	0 N.	Wo	IPB S	+. 13/	Himo	12,1	WARY IAV	5,2006 d 21287
Sta	te	31. Date filed (Month, Day, Year)	32. Reg	tràr's Signa	ature	1 .	P. m.		V-1				

			1 - State of Maryland / Department / Departme	artment of Health and M rtificate of Death		iene eg. No. 04729
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Robert D. Scarborough, Sr.		2. Date of Deat Month FeD.	15 2006 3. Time of Death 11:00 A M
	Examin		4a. Facility Name (If not institution, give street and number) 6153 Forest Lane	4b. City, Town, or Location of Death Eldersburg		4c. County of Death Carroll
	Funeral Director		5. Social Security Number 213-16-4898 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) 87 Yrs. Usuat Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 5,	Year) 9. Birthplace (State or Foreign Country) Mary Land
	hours effer death with the Maryland lurel', or items 23s or 28s-f show at Exertinal must be notified at	Director	10a. State 10b. County 10c. City, Town or Lo MD Carroll Eldersbu 10e. Street and Number	Irg 10f. Zip Code		10d. Inside City Limits 1 □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
036	be filed within 72 hours efter death with the Marylan Ital Hygiene. Id other than "naturel", or lieme 23s or 28s-f show svent, the Medical Examinar must be notified at	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	21784 Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecrify Yes or No-	Inited States 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ent, the Medice.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) SMAN	ing	16b. Kind of Business/Industry
ryland		To Be	17. Father's Name (First, Middle, Last) Robert C. Scarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	18. Mother's Nam- Rachel E	. Little	2
	1 and 2 Heelth a mm 27 i		Evelyn Scarborou h Wife 6153 20a. Method of Disposition 1 We Burial 2 Cremation 3 Removal from State 20b. Place of Disposementary, crematery,	Forest Lane Elde	rsburg,	MD 21784 20c. Location - City or Town, State
Baltimore,	permit. Pages Depertment of I Important: If its eny injury or o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Mem. Park 1 200 2. Name and Address of Facility prrier-Oueen Funer 212 W. Old Liberty	6 'S	& Crematory, P.A. Vinfield, MD, 21784
8/60,	Physician and /Medical Examiner transit the purial-transit	dical Examiner	23a Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		or respiratory arre	
.O. Box 6	law requires that the death certificate be executed es been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires thet been signed k should be det	b	Part II. Other significant conditions contributing to death but not resulting in the uncertainty of the land of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting in the uncertainty of the conditions contributing to death but not resulting to the conditions contributing to the conditions of the conditions conditions contributing to the conditions of the con	nderlying cause given in Part I.	23e. Did tob	oacco use contribute to the cause of death?
-	The ete h page	e Completed	25. Was case referred to medical	20.00		prior to completion of cause of death? TNo 1 Yes 2 No
Division of Vi	this aid	Certification; To B	examiner? 1 Yes 22 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	f 28c. Injury at Work? M 1 Tyes 2 No	me 5 Resider 28d. Describe ho	nce 6 Other (Specify) w injury occurred
N N	To the Hospital or Attending I within 24 hours after death. To the Funerei Director: After completely filled in by the funer	sal Certif	4 Homicide determined 289. Place of injury - At nome, farm, str building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death	h occurred at the time, date and place	City or Town,	NICO(C) and mapper as stated
)	To the Ho within 24 To the Fu	Medical	one) 29b. Signature and title organization and/or in	vestigation, in my opinion, death occurr	ed at the time, da	ate and place, and due to the cause(s) Od. Date signed (Month, Day, Year)
,	8		30 Name and address of person who completed cause of death (Item 23a) (Type, Struck St	Print) eurse tra NIVA	511	2/15/06 lex6us MD 2/98
0	Sta Registr		31. Date filed (Month, Day, Year) 32. Eligistrar's Signature FFR 1 7 2006	carle	100	5/7/8

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Yeer **Physician** EADORNE AROUD 02 06 06 /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Genesis Long Green Nursing Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number unk 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Funeral 1⊠M 2□ F Months Yrs. Director 94 Feb 12, Maryland Usual Residence of Decedent filed within 72 hours efter death with the Marylend Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23a or 28a-f sho the Modical Examiner must be notified at ty⊡Yes 2□No MD Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 115 E. Melrose Avenue 21212 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be illed w Department of Heelth and Mentel Hygien Important: if Item 27 is marked other th, any Injury or other treumatic event, the once. 12 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Samuel Everett Seaborne Sallie Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Gwendolyn Seaborne/sister 2604 N. Longwood Street Baltimore, MD 21216 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director ILLEC 21201 Baltimore, MD terrice 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, on heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical COMEESTIVE HEART FAILURE Examiner Due to (or es e consequence of) Physician/Medical Examiner the ettending physician end hed for use as the bunel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): cete hes been signed by the capage 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ISEASE à 24b. Were autopsy findings availeble prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Ves 2 140 1LI Ves 2LINO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Living Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? I or Attending P. efter death. Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es steted.

Medical Exeminer: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 2006 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Punt) BACTO, HE16HT MEHUE

36 Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

FEB

7 2006

			1 - For State Registrar	State of M	laryland /		artment rtificate			and M	F	leg. Nö.	00	6	04731
	Physici	an	1. Decedent's Name (First, Middle, Las	it)							Date of Dea Month	Day		'ear	3. Time of Death
	/Medic		Alberta 4a. Facility Name (If not institution, give	street and number)		Taylo		Location o		Februar	_	County of		10:10 P ^M
	LAGIIII	iei	405 Stefan Court		,				oint				ltim		
	Funeral Director		207-30-0023	9x 7. A □ M 2 X F	ge (In yrs. last 76	birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 4,	192	9	Birthp Cour FLO	place (State or Foreign ntry) rida
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							1	10d. Inside City Limits
	Man a-f sh	tor	MD. Baltimon	ce	Nor	th P	oint								1 ☐ Yes 2√ No
	vith the	Director	10e. Street and Number				10f. Zip				1	10g. Citiz	en of Wh	at Cour	ntry?
	eath v	Funerai	405 Stefan Court	12. Was Decedent	Ever in II S	12.1		1222	nania Oria	nin 2 /Sno	ody Vac as Na		SA	Amaria	can Indian,
920	within 72 hours after death with the Maryland ene. Than "naturel", or items 23s or 28s-f show he Madical Exeminer must be notified at	<u>م</u>	1 ☐ Never Married 2 ☐ Married \$\frac{3}{2}\text{Widowed 4 ☐ Divorced}	Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates:	?		f Yes, spec		Specify:	, Puerto	ecity Yes or No- Rican, etc.)			White,	etc.
5 0	n 72 hours "naturel", colon Exe	eted	15. Decedent's Ed (Specify only highest gra		10	(Giva	lent's Usua kind of wor	k done d	uring most	of worki	ing	16b. Kir	d of Busi	ness/In	dustry
121	d within giene. sr than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired)	orang most	or mornin	9	_			
d 2		Be Co	8 years 17. Father's Name (First, Middle, Last)			HOU	sewife		18. Mothe	r's Name	(First, Middle,		Home Sumame)	<u> </u>	
/lan	should be filed void Mental Hygie marked other tomatic event. It	To B	Ray S. Straham						Isab	ell	F. Leigh	h			
Man	C 42 2 2		19a. Informant's Name/Relationship (7								il Route Number				Code)
ē,	s 1 end : if Health item 27 other tr		Ida Taylor 20a. Method of Disposition	Daughter	20b. Place	of Dispo	sition (Nam	e of		Nort ebru	h Point				own, State
ê .	Pages nent of nt: If i		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				ratory or ot cremat			ebru 7, 2	ary		imore	•	
Baltimore, Maryland 21215-0036	permit. Pages to Department of Himportant: If ite eny injury or ot once.		21. Smalure of Funeral Service Licen	Cor	rnell	22	Name and Connell 7110 S	Addres	of Facility uner	al H	ome Of I Road, I	Dund	alk,E	P.A.	21222
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each I	d the death. D	ot ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,	a I IX p	, u	Approximate Interval Between
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aW	140	CA	DIA	+C	IN	FA	2017	94			Onset and Death
	Examiner			Due to (or as	a consequenc	e of):									
7		ner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e of):									
V	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		0								4	
8760,	sicien burial	aiE		. Due to (or as	a consequenc	e or):									
687	micate g phys	ledicai		d										+	
Вох	death certificate be executed e ettending physicien and od for use as the burial-transit	Physician/Me	200. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy 2 Petal dea	ıth 3⊡	Ectopic pre	onancy				2	3d. Date o		,
o.]	ne dea the et	ysici	in the past 12 ponths? 1 □ Yes 2 € No 9 □ Unknown	4□Pregnant a 9□Unknown	t time of death	5 □	Other (spe	ecify)					Month		Day Year
Q	The law requires that the de ste has been signed by the c page 2 should be deteched to	by Ph	Part II. Other significant conditions co	ontributing to death t	out not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco us	e contribu	ite to th	ne cause of death?
spa	w requires been sig	ed b									1 🗆 Ye	es 🔀	No 31] Prob	abły 4 □Unknown
ecc .	nas be a 2 sh	Completed									24a. Was a autops		24b. Wei	e autor	psy findings available inpletion of cause of
<u>교</u>			95 W	-							perform 1 ☐ Yes	ned? No	dea	th?	2 No
5	r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/	Outnation	3 DO	Other		of Death	ne 5X Reside			· · · · · · · · · · · · · · · · · · ·	
Division of Vital Records,	fter thi		27. Manner Death	28a. Date of Inju (Month, Da	rv 28b	. Time of Injury		Sc. Injury Work			28d. Describe ho			Specify	"
Sio	Attending or death. ector: After by the fune	icatl	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2 N						
Div	글루	Certification:	4 Homicide determined	building, ei	tc. (Specify)						City or Towr	n, State)			i Route Number,
	within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier Sertifying Phyone) Medical Exam	rsician: To the best iner: On the basis of and manner st	or examination :	ge, death and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deatl	f place, a h occurre	and due to the ca ed at the time, d	ause(s) a ate and p	ind mann	er as st due to	ated. the cause(s)
	within To the	Me	29b. Signature and title of certifier	0			29c.	License	number		2	9d. Date	signed (A	Agnth, I	Day, Year)
			Jan Mas	X/ W	7		D	20	831			21	16	10	6
	5	4	30. Name and address of person who of	Theet	Bal	(Type,	orint)	Mar	na	zl	21204	=	- 8	uz	= 216
Ī	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 7 7	32. Figistr	ar's Signature		28450								

			1 – For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of		nd Mental H	ygiene Reg. No.	04732	2
	Physic		Decedent's Name (First, Middle, Last) Mary McCue Tanner					2. Date of C Month FEB	Death	Year 6:59 P	th M
	/Medi Exami		4a. Facility Name (If not institution, give				TIMOR	Death	4c. Count	y ol Death	
	Funeral Director		5. Social Security Number 6. Sex	IM 250715	ge (In yrs. last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24			9. Birthplace (State or For Country)	reign
	p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		- 07/31	, 1317	10d. Inside City Lin	mits
	death with the Maryland ims 23a or 28a-1 show imstite notified at	Director	MD Baltimon 10e. Street and Number	re	Catonsv	ille 10f. Zip Cod	9		10g. Citizen ol	1 ☐ Yes ¾☐ What Country?	No
	re, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryla f. Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	by Funerai	812 Fairway Avenue 11. Marital Status 1	12. Was Decedent Armed Forces 1 Tyes 2 15 If Yes, Give Year or Dates:	No			n? (Specify Yes or Neuerto Rican, etc.)	No. 14 Ra Bla	ed States ce-American Indian, ack, White, etc. fy: White	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Inportant: If tam 27 is marked other than "natural, or itel may injury or other traumatic event, the Madical Examina and.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+) (Give	dent's Usual Occ kind of work do: DO NOT use ret Okkeeper	ne during most o ired)	if working		Business/Industry	
	yland out be filed Mental Hygarked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Homer Tanner		DX	DAACEPEL	18. Mother's	s Name (First, Midd. zabeth Mu	le, Maiden Suma	unting	
	, Mar and 2 sh salth and n 27 ls m er traum		19a. Informant's Name/Relationship (Ty, Keith Tanner (Neph					or Rural Route Num Catonsvi	•		
	imore Pages 1 ment of He ant: If Itan ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify).	emoval from State	Bayview	crematory or other p	ory 0	Date 2/17/2006	Baltim	•	
	Balt Permit. Depend import any inj		21. Signature of Foreiral Service License	Lind		Name and Add Hubbard 1107 Wil	Funeral kens Ave	Home, In enue, Bal	c. timore,	MD. 21229	
•	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	A S	d the death. Do not entine. PIRATIO a consequence of):	0	Nying, such as ca		arrest,	Approximate Interval Between Onset and Death	
pt.	8760, cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):						
	O. Box 6 I the death certific by the attending p	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnal				ate ol delivery onth Day Year	
9.1	rds, F quires tha n signed ud be det	þ	Part II. Other significant conditions con				given in Part I.			tribute to the cause of death?	
TANNER	Vital Records, slcian: The law requires t certificate has been signe rector, page 2 should be or	Completed		11ABET	SION ES MELL	ITUS		per	formed?	Were autopsy lindings available prior to completion of cause death? 1 Yes 2 No	ol ol
£	Vital Fision: The certificate	Be	25. Was case referred to medical examiner?	ospital:)ther	Death Check only	12.		_
1.	Phy Phy of	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28c. In	4 U Nursi		sidence 6 □Ott how injury occur		
	Division tal or Attending rs efter death. al Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	jury - At home, farm, str c. (Specify)	eet, factory, offic	ee .	28f. Location City or To	(Street and Numi own, State)	ber or Rural Route Number,	
	the Hospl iin 24 hou the Funer ipletely fill	edicai	29a. Certifier 1 √ Certifying Physical (Check only one) 2 ☐ Medical Examination	ician: To the best ter: On the basis o and manner st	of my knowledge, death of examination and/or in- ated.	vestigation, in m	time, date and p y opinion, death	place, and due to the occurred at the time	a cause(s) and in b, date and place,	anner as stated. and due to the cause(s)	
	To To Con	Σ	29b. Signature and title of certifier G. Chartury	edi 1	4 D		924			ed (Month, Day, Year)	
	12			well to	leath (Item 23a) (Type,	Print) NAVE	NUE, B	ALTIMO	RE, MI)	, 21229	
	Sta Regist	_	31. Date liled (Month, Day, Year) FEB 1 7 2006	32. Registr	ar's Signature	9					

		1 - For State Registrar	State of M	Marylar	nd / Depa <i>Cei</i>	artmer rtifica	nt of H te of L	ealth a Death	and Me		ene	96	04733
Physicia /Medic		1. Decedent's Name (First, Middle, Last	lume	er					1	2. Date of Death Month	Day Ole	Year	3. Time of Death 2:10 AM
Examin		4a. Facility Name (If not institution, give Blue Point Nursi	street and numbe	er)			Town, or	Location o	of Death		4c. Count	y of Death	_ 2.10 A
Funeral Director		5. Social Security Number 6. Se			last birthday) Yrs.		r 1 Year	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Oct 25,	Year) 1969	9. Birthp Coun Mary	
Maryland f ehow	tor	10a. State 10b. County MD		10c. Cit	y, Town or Lo						-	1	0d. Inside City Lim
with the	i Director	10e. Street and Number 6026 Regis Road				10f. Zij		006		10	g. Citizen of		itry?
s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth and Menial Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ∑No		Was Dece f Yes, spe 1 ☐ Yes	dent of Hi orfy Cuba	206 spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ity Yes or No- ican, etc.)	Bla	ce - Americ lck, White, fy: bla	etc.
within 72 h ene. then "natu he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4c	or 5+)	life.	kind of wo	ork done d ise retired,	u <i>ring</i> most	of working	7	6b. Kind of E	Business/Inc	dustry
buld be filed Mental Hygiarked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Robert Turner	0		1000	_prej	parer	18. Mother	r's Name (First, Middle, M	resta Maiden Surman		
is 1 end 2 should to the library of Heelth and Ment Item 27 ie marker other treumatic		19a. Informant's Name/Relationship (7) Josie Bowman/moth						nd Numbei	r or Rural	Route Number, Baltimo			
permit. Pages 1 of Depertment of He Important: if Item any injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from Star	te C	Place of Dispo cemetery, crem	sition (Na natory or o	me of other place)	Da	te 2	Oc. Location	· City or To	wn, State
permit. Deperti Importi any inj once.		21. Signature of Funeral Stryice Licens Ron 3 d S. V	lade Dij	CICIO	Ba	ltimo	ore,	MD 2	1201	655 W.		ore S	treet
Physician /Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	AIDS	iline.		er the mod	de of dying	, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
cate be chysicie the but	dicai	L.	d.	as a conseq	dence or):								
The law requires thet the death certificate has been signed by the attending plaga 2 should be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	Ideath 3□	Ectopic pi Other (sp						ate of delive onth	ry Day Year
w requires thet been signed b should be deta	ed by Pr	Part II. Other significant conditions cor	ntributing to death	but not res	ulting in the ur	iderlying o	ause give	n in Part I.			acco use con	tribute to th	e cause of death?
	Completed								_	24a. Was an autopsy perform	ed2	prior to con death?	osy findings availat npletion of cause o 2 No
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:				Othe			Check only one			
Attending Phy ir death. ector: After this by the funeral d	ation: To	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ijury	ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 Nur		5 Resident)
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completaty filled in by the funeral	Certification:	3 Suicide 6 Could not determine	28e. Place of I building,	njury - At ho etc. (Specif)	ome, farm, stre	eet, factory				f. Location (Stre City or Town,	et and Numi State)	ber or Rural	Route Number,
To the Hospital or within 24 hours effe within 24 hours effe to the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the besier: On the basis and manner:	or examina	wledge, death tion and/or inv	occurred estigation	at the time, in my op	e, date and inion, death	place, and	d due to the cau at the time, dat	use(s) and m e and place,	anner as sta and due to	ated. the cause(s)
To th within To th compl	Me	29b. Signature and titleyof certifier					. License		+65	. 29	d. Date signe	106 ·	Dey, Year)
		30. Name and address of person who co	mpleted cause of	death (Item 25Mail	n Shet	Print) SUITE	200	Reis	Hersto	INN, ME	2/1	36	
Stat Registra	_	31. Date filed (Month, Day, Year) FEB 1 7 2006	A2. Regis	trar's Signa	ture	K)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Amend item #14 Per FH C852 2/17/06 JH Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year February 2021 awrence 12,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore 1. NA 7. Age (In yrs. last birthday) Johns ODKI ITT Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 100 M 2 F 11 MD 219.30.0435 Director 09.05.1934 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is markad othar than "natural", or itams 23a or 28a-f show traumatic evant, the Madical Examinar must be notified at NA 1 Ocyes 2 No Funeral Director BALTIMORE MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 408 VENABLE AVENUE 21218 IJSA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC EDUCATION NA 12 14 GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Pages 1 and 2 should be 1 nent of Health and Mental I ant: If itam 27 is markad o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST., TARA SPICER DAUGHTER 2132 N. CALLIERT BAGO. MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) GREENMOUNT 02.16.06 BALTO. MD 22. Name and Address of Facility
CREMATION SECULCES
5151 BAGO. NATE PIKE, BAUTO. MO 21. Sign ture of Fun-Ital Service License augh 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cardio9 6 days ni /Medical Due to (or as a consequence of): Examiner erior Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner be executed signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ulcer duode nal 1 Tyes 3 Probably 4 Unknown tachin cardia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No renal acute 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner?
1 X yes 2 \(\text{ No} \) Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital within 24 hours a To tha Funarai Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) ebruary

Registrar

d

State

600 N. Wolfe

St Tower 110 BALTIMORE MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASSILEVA

32. Registrar's Signature

Μ.

7 2006

CHRISTINA 31. Date filed (Month, Day, Year)

FEB 1

Patient mown as William Wallers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea **Physician** WILLIAM ANDERSON WALTERS 11:55 PM FEBRUARY 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore City Boutimore NA Ob. 18 1943 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**⊠**M 2□F 216.40.0244 Director 62 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ehow item 27 is marked other then "naturel", or items 23a or 28a-f ehov other traumatic event, the Madical Examinar must be notified at Director 1 XYes 2 No MD NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 139 9. WOODINGTON ROAD USA 21220 12. Was Decedent Ever in U.S. Armed Forces?

1 02 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 257 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 2 YRS DRIVER 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental B GEORGE WALTERS LOUISE FREEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) OPHEUR KEYS-WALTERS 739 S. WOODINGTON RD. BALTO. MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny Injury or ot 1 Surial 2 Cremation 3 Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 02.24.06 OWINGS MIUS, MD 21. Signiture of Funeral Service Lice VAUGHN C. GREENE FUNERAL SERVICE 2 augh 5151 BAUTO. NATE PIKE, BAUTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Pulseless Electrical 30moutes /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) S auentially list and in any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death signed by the a d be detached f 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Failure Heart 1 Yes 2 No 3 Probably 4 Hiknown Completed dependent Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Obstructive Pulmonary Chronic 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1, Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ANatural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Starrow bui RES-000 February 14,2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVI STAVROU, Hospital MO, Siraci 9

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

7 2006

32. Registrar's Signature

Physician /Medical Examiner **Funeral** Director the Maryland 10a. State 28a-f show Director ö Itsms 23a Funeral δ

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) the Medical Examiner must be notified at Maryland 11. Marital Status 72 hours after Baltimore, Maryland 21215-0036 "natural", or Completed other than 12 or other traumatic avant, 2 should be fit and Mental Fit marked of permit. Pages 1 and 2 sh Department of Health and Important: If Itsm 27 Is m sny Injury or other traum once. **Physician** /Medical Examiner

2. Date of Death 3. Time of Death FEBRUARY 12:05 AM 2006 Dollis Killen Williams 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL SAINT AGNES BALTIMORE n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5233 Security Number 233 30 - 2398 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🔀 F Yrs 89 Nov 29, 1916 Virginia Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4736 Vancouver Road 21229 United States 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security claims adiuster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Smith Killen Mattie Whitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet A. Kerr - daughter 108 Armagh Drive, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2/13/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS DAYS Due to (or as a consequence of): OSTRIDIUM DIFICILE COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death signed by the atte in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident Injury 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 17602 Vinutalmen 14.1). TEBRUARY 12 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BALTIMORE, MARYLAND KNINTKIENIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 5 per 1h 9865 3-14-07 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

Registrar

FEB 1 7 2006

				1 - For Stete Registrer	State	of Marylar		artment <i>rtificate</i>			Mental Hy	gieñe	6	04737
		Physici		1. Decedent's Name (First, Midd George W. Woll							2. Date of De Month	Day .	2hol	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institutio	n, give street and nu	ımber)	-	4b. City, T	own, or Loc	cation of Death		4. Count	y of Death	ioocy
		Sa go s		Upper Chesape					el Ai				rford	
		Funeral Director		5. Social Security Number 220-14-3114	6. Sex 1 ☐ M 2 ☐ F X	7. Age (In yrs. 81	. last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da Dec. 26	1924	9. Birthp Coun Mary	lace (State or Foreign hty) Land
		land		Usual Residence of Decedent 10a. State 10b. County	1	10c. Ci	ity, Town or Lo	cation					1	0d. Inside City Limits
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		th the	Funeral Director	10e. Street and Number	514			10f. Zip 0				10g. Citizen of	What Coun	ntry?
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5		er de	nue	11. Marital Status	Armed F		J.S. 13.	Was Decede	nt of Hispa y Cuban, M	nic Origin? (Si lexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Rad Bla	ce - Americ ck, White,	
0	36	irs aft	by F	1 Never Married 25 Mar 3 Widowed 4 Divorces	If Yes G	ve		1 ☐ Yes 2	No S	pecify:		Specif	_{y:} wh	ite
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	anc	a la b	Be	Henry Wolbert	Last)						ne <i>(First, Middl</i> e ne Traut	, Maiden Sumar :ner	ne)	
d	Maryland	2 should and Men Is marks sumatic	မ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (er, City or Town	State, Zip	Code)
0	N	1 and 2 Health a Iom 27 Is		Irma Wolbert/	wife									Md. 21009
14/06	nore	T of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		State	Place of Dispo cemetery, crer avview	natory or oth	er place)	2/19	Date 3/2006	20c. Location Baltim	•	
त	altin	permit. Pag Department Important: any injury once.		4 □ Donation 5 □ Other (5		Д,								
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8	9	sath certific ettending p for use as	/Med	IF FEMALE:	23c It vas ou	tcome of pregn	ancv							
$\tilde{\omega}$	Вох	death etten	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	oirth 2 Feta	al death 3	Ectopic pred					ite of delive onth	Day Year
#	0	that the de ad by the detached	hysi	9 Unknown	9□ Unkr	own								
6	S, F	res tha igned be de	by Physician/Me	Part II. Other significant conditi	ons contributing to d	leath but not res	sulting in the u	nderlying cau	ise given in	Part I.	23e. Did (obacco use con	tribute to th	e cause of death?
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eorge	Record	e law hes b	Completed								24a. Was auto	psy	prior to con	psy findings available inpletion of cause of
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+	10	Attending Physician: r death. sctor: After this certific by the funeral director.	n: To	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of		c. Injury at Work?	+ □ Nursing H		dence 6 Oth		/)
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101 bert	Division	or Dir	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Place build	of Injury - At hing, etc. (Speci	nome, farm, str ify)	eet, factory,	office		28f. Location (City or To	Street and Numi wn, State)	ber or Rura	l Route Number,
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		12		1100	who completed cau	se of death (Ite	m 23a) (Type,	Print)	THE	Rd	RF	LAIR,	Md	21016.
	*	Sta		31. Date filed (Month, Day, Year,	32. F	mistrar's Sign		Carle D		1,44				
	*	Registr	ar	een 1	7 2006	PA-G.AT O	D A	100						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Weisiger **Physician** Month Year Michael February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Hospital city The Johns Hopkins 8. Date of Birth (Month, Day, Year) Jan. 25,1957 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1**X** M 2□ F Yrs. Director Maryland 49 213-66-3712 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthen "natural", or Iteme 23a or 28a-1 ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1915 Frames Road deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Soecity: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Chemical 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unkn. and Mental I Pages 1 and 2 should be Weisiger Mildred Alice Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 Frames Road Dundalk, Maryland 21222 If Item 27 I Janice L. Zuk (Fiance) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Hilltop Service Corp. 2/18/2006 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. **199** 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction 4 hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as the attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at id be deteched fo 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pege 2 : autopsy performed? Yes 2 0 certificate 1 Yes To the Hospitel or Attending Physician: efter death.

Director: After this certific
Jin by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient မှ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **Division** 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined within 24 hours efter de To the Funarel Directo completely tilled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gunly Schome MD February 15, 2005 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 241 Emily Schopick, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 31. Date filed (Mon 32 Registrar's Signature State Registrar

		1 - For State Registrar	State of Maryland / Dep Ce	artment of Health		tal Hygien	1000	04739
Physicia		1. Decedent's Name (First, Middle, Las		West-FAI1	2.1	Date of Death	Pay Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location			c. County of Death	700
Funeral Director		5. Social Security Number 6. Sr 212-01-2878	ax 7. Age (In yrs. last birthday, □ M 2X7 F 87 Yrs.	If Under 1 Year II Under Months Days Hours	er 24 Hrs. 8. 1	Date of Birth Month, Day, Yea Lt. 5, 19	9 Birtho	lace (State or Foreign try) Land
ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				Od. Inside City Limits
h the Ma r 28a-f e	Funeral Director	Maryland Howard 10e. Street and Number		101. Zip Code		10g. C	Citizen of What Cour	1 ☐ Yes 2X No
eeth wit ne 23e c must be	eral D	8720 Ridge Road,	•	21043 Was Decedent of Hispanic C	Origin? (Specify	Yes or No-	U.S.A.	an Indian
be filed within 72 hours after deeth with the Maryland be filed within 72 hours after deeth with the Maryland all by given and other than "natural", or items 23s or 28s-f show event, the Madical Examinar must be notified at	ρ	1 ☐ Never Married 2 🗖 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specify	an, Puerto Rica	in, etc.)	Black, White,	
nin 72 ho	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give	dent's Usual Occupation a kind of work done during mo DO NOT use retired)		16b.	Kind of Business/In	dustry
illed with Hygiene ther tha nt, the		12th Grade 17. Father's Name (First, Middle, Last)	Medic	al Equipment		rst, Middle, Maide	orthern Pl en Sumame)	rarmacy
y carror in a hould be filed a Mental Hygi narked other natic event,	To Be	Frank Kozel		Jose	ephine	(Surnam	ie Unknown	
t and 2 sh t and 2 sh Health end em 27 ls m ther treum		Mr. Myron Westfall 20a. Method of Disposition	(husband) 8720	ing Address (Street and Num Ridge Rd., A osition (Name of		Ellico		MD 21043
Pages ment of tent: If It		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Parkwood				ltimore, M	
permit. Pag Depritment Importent: I any injury o		21. Signature of Funeral Service Licen		2. Name and Address of Fac 705 Belair Rd				2.5
Physician /Medical		23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enone cause on each line. a. ACHE MYDCALO Due to (or as a consequence of):	iter the mode of dying, such a	as cardiac or re-	spiratory arrest,		Approximate Interval Between Onset and Death
Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. SEPSIS Due to (or as a consequence of):				1	D days
cate be executed physicien and the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
OI VICAL DOX 00 Physicien: The law requires that the death certificat this certificate has been signed by the ettending phy ral director, page 2 should be detached for use es th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
w requires that the tendent signed by should be detact	ρ	Part II. Other significant conditions	ontributing to death but not resulting in the	underlying cause given in Par	t I.		o use contribute to the	ne cause of death?
The law rec	Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mptetion of cause of
VICAT iclen: 1 certificel ector, p	Be	25. Was case referred to medicat examiner?	Hospital:	Othor	ice of Death (C	heck only one)		
Phys	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury 28b. Time			5 Residence	6 ☐Other (Specifically occurred	y)
Attending or death.	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Work? M 1 ☐ Yes 2[□No			
To the Hospital or Attending Physicien: The law within 24 buous after death. To the Funeral Director: Attent his certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At home, larm, s building, etc. (Specify)	treet, factory, office	281.	Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 12 Certifying Ph (Check only 2 Medicat Exan	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date investigation, in my opinion, d	and place, and leath occurred a	due to the cause it the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	1001	29c. License numbe		29d. [Date signed (Month,	Day, Year)
3		30. Name and address of person who	Medical dodo completed cause of death (Item 23a) (Type	Print)		Itel	DELIBRY /	4,2006
	•	31. Date liled (Month, Day, Year)	Men 600 M· U	2016 St. B.	A Himan	8, MAK	y land	21287
Sta	te		2006	Rugallo B			•	

GLORIA WILSON 06-01 RJ

А 09	6		Please Type	or Print in Black In	delible Ink.	Ensure A	II Copies A	re Legible.	
			1 - State Registrar	e of Maryland / Depa Cer	artment of F			ene 006	04740
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Gloria Wilson				Februar	· · · · · · · · · · · · · · · · · · ·	
	Examin	ner	4a. Facility Name (If not institution, give street and		' -	r Location of Death		4c. County of Deat	h
		-	Johns Hopkins Bayview 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)			9. Date of Birth	0.8:-	
	Funeral Director		216-66-3503		Months Days	Hours Min.	8. Date of Birth (Month, Day, Y March 6,	(ear) Co	nplace (State or Foreign untry) 7 land
_			Usual Residence of Decedent		L		Parcir 0,	1999 Mar	Taria
	nylan how	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	deeth with the Maryland ma 23a or 28a-f ahow rnust be notified at	Director	Maryland	Baltimor					Mo 2 No
	Mith th	드 -	10e. Street and Number		10f. Zip Code			g. Citizen of What Co	untry?
	eeth v	erai	3719 Centre Place	Decedent Ever in U.S. 13.1	21224	linonnia Origina (Co		U.S.A.	dan India
	iter d	Funeral	Arme	d Forces?	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
9500-61717	ursal	Ď	3 ☐ Widowed 43 ☐ Divorced Year	Specify:		Specify: W	hite		
2	be filed within 72 hours after deeth with the Marylan Hygiene. do other than "natural", or Itama 23a or 28a-f ahow avant, the Maulical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple	pation during most of work	ing 16	8b. Kind of Business/			
V	ighi.	npie	Elementary/Secondary (0-12) Colle	d)		-1 ~			
7	led w lygier her th	S	17. Father's Name (First, Middle, Last)	Facto	ory Worke			Plastic C	ompany
=	ould be fi Mentel H arked ot atic avar	Be	Robert A. Wilson				e (First, Middle, Ma Jean Wels		
	2 should be and Mentel is marked sumatic av	မ	19a. Informant's Name/Relationship (Type, Print,	10b Mailie	an Address /Street			City or Town, State, 2	Fin Code)
	id 2 s ith an 27 ts traus		Bobbi Jo Wilson (Daugh					Maryland 2	
T)	s 1 and 2 should if Health and Mar Itam 27 is marke other traumatic		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Ť		c. Location - City or	
Ē	Page ento nt: If ry or	1 8	1XDBurial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (Specify)		natory or other place. 1 Mem. Ge		6,2006 Ba	ltimore,	Marvland
Dalillino	permit. Pages to Department of Hamportant: If Ita any injury or of once.		21 Sign ture of funding 5 mins to insee					Home, P.A	_
ñ	80 = 8	1	1200	1	407 01d	uzuzinski Fastern A	venue. Es	sex Marv	land 21221
			23a. Part. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not ent on each line.	ter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
_{er si} . F	Physician		Immediate Cause (Final disease or condition	Centrocuil	tun				Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):					
ľ	_xa	-	Sequentially list conditions, b.	e to (or as a consequence of):					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence or).					
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ğ	death certificate b attending physic ifor use as the b	hysician/Medic	230. Was decedent pregnant	i, outcome of pregnancy ive birth 2 ☐ Fetel death 3 ☐	Ectopic pregnancy	,		23d. Date of del	
-	e death the atten ned for u	Sici	1 Yes 2TNNo		Other (specify)			Month	Day Year
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Ś	ires t signe d be d	d by	at it. Strong significant conditions contributing	to death but not resulting in the di	ndenying cause giv	enin Panti,	1 Tes	n-are	obably 4 Tunknown
5	v requ	ompleted							
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	ician: Thi certificete rector, peg	ပိ	25. Was case referred to medical			00 Div. (D.)	12 Ves 2		2 ☐ No
>		0 8	examiner?	1 ☐ Inpatient 2 💆 ER/Outpatien	ot 3CIDOA Oth	06	h Check only one	ce 6 ☐Other (Spec	nifiel
5	g Phya ter this neral di	F.	27. Manner of Death 28a. [Date of Injury 28b. Time of			28d. Describe how	injury occurred j	10112
0	andin ath. or: Afr	atio	ZX Accident investigation 2	Month, Day Year) Injury -17-06 5:171	4 M 10	Yes 2X≦No	DECOUNCE	touch wen	1.
DIVISION	rrAtte ter de irecto	Certification;	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm, strouilding, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	ot and Number of Di	Levelenel Are
ַ	oital ours of real D			hom			Baltimo	XP, KID ?	21224
	To the Hospital or Attending Phymin 24 hours elter death. To the Funarial Director: After the completely filled in by the funeral	edicai	(Check only ZE Medical Examiner: On t	o the best of my knowledge, death he basis of examination and/or in manner stated.	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	Veith To t	Σ	29b. Signature and title of certifier	111	29c. Licens OCMI		290 F	d. Date signed (Monti	n, Day, Year)
	1		MICHEL	00				•	
2	/		30. Name, and address of person who completed	ause of death (Item 23a) (Type,	Print) 111 1	Penn Stre	et Balti	more, Mar	yland 21201
	Sta	l o	31. Date filed (Month, Day, Year)	32 Aegistrar's Signature					
	316	:115		M. Lo A.	200				

Registrar

FEB 1 7 2006 32 aegistrar's Signature

		1 - For State Registrer	State of Maryla		artment of He			ZUUD	04741
		Registrer 1. Decedent's Name (First, Middle, Land)	ast)	Ce	Tillicate of D	realii	2. Date of Death	g. No.	3. Time of Death
	ysician	Liliane Woel	for				Month Februar	Day Year	
733	Medical kaminer	4a. Facility Name (If not institution, gi			4b. City, Town, or I	ocation of Death	repruar	4c. County of Death	1 3:10 <u>pill</u>
		2234 Graythorn R			Middle R			Baltimor	
	neral	1	1 M 2 M	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	Year) 9. Birth	nplace (State or Foreign untry)
	ector	218-50-6914 Usual Residence of Decedent	4	9 ***.			July 17	, 1956 Ma	ryland
5-0036 72 hours after death with the Maryland naturel; or Iteme 23a or 28a-f ehow	1 .	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
he Ma	Director	Maryland Baltim	ore M	iddle R					1 ☐ Yes 2 🔀 No
with ti	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
Jeath ne 23	for must	2234 Graythorn R	load 12. Was Decedent Ever in	n U.S. 13.	21 220 Was Decedent of His	panic Origin? (Spe		J. S. A. 14. Race - Amer	ican Indian
or Iter	Fur	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		Was Decedent of His If Yes, specify Cuban		Rican, etc.)	Black, White	
Z1Z15-0036 d within 72 hours af giene. or then "naturel; or	the Medical Examiner must be rotified at ompleted by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite
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offied within I Hygiene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Telle				Banking	
	e C	17. Father's Name (First, Middle, Las	et)	10116		18. Mother's Name	(First, Middle, Ma		
arylan should be nd Mental		George Albert	Monath, SR.			Marie 1	LeRoy		
Maryland d 2 should be file th and Mental Hy ?? Ie marked oth	- F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street ar	nd Number or Rura	l Route Number,	City or Town, State, Z	ip Code)
C = 14	other treumatic	Kenneth Woelfer		2234 b. Place of Dispo	Graythorn			ver, Maryl	
Pages Pages net of int: If It	0 00 0	1 ☐ Burial 2 🛱 Cremation 3 [Removal from State	cemetery, crei	matory or other place,			Dc. Location - City or	
Baltimore, permit. Pages 1 a Department of Hea Important: If Item	Injur	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			Crematory 2. Name and Address			altimore,	Maryland
B gg E	ç a	115-0		I	2. Name and Address Bruzdzinsk 1407 Old E	i Funera. astern a	l Home Pi	A ssex, Mary	land 21221
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/Med Exam		resulting in death)	Due to (or as a cons	sequence of):	MADO			11001001	· Yr
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		ľ	1- State of Mar State of Mar		artment of H			ene 06	04742
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death
	Physici: /Medic		RUTH WYNN					Y 11, 2006	9:00p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			2600 BOARMAN AVE.		BALTIN	10RE		N/A	
	Funeral Director			In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 11-5-19	Year) 9. Birthy Cou 19 MARY I	place (State or Foreign ntry) LAND
	Б .		Usual Residence of Decedent	0- Cir. T					104 1-14 00-11-1-
	anyla	Ļ		Oc. City, Town or Lo					10d. Inside City Limits 1 ∑XYes 2 ☐ No
	Ba-f	Director	MD. N/A	BALTIMOR					
	with th	D.	10e. Street and Number		10f. Zip Code		10	ng. Citizen of What Cou	ntry?
	s 23g	rai	2600 BOARMAN AVE .	-5116	2121			USA 14. Race - Ameri	en ladias
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumatic event. Its Medical Examinar must be notified at ance.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 31∑ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🗓 No	Specify:	Rican, etc.)	Black, White,	etc.
Š	2 hou	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/In	ndustry
75	hin 7	pie	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	life.	kind of work done DO NOT use retired	during most of world)	king	BRAGGER GU	rman -
2	d with	E	-8 -		COCKER			DEPT. STOR	E
덜	e file al Hy othe vent.	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, N	Maiden Sumame)	
Maryland	ould by Ments	Tof	CHARLES HAMMOND	101 14 11	(2)		E DORSEY		0.71
Mai	ind 2 st alth and 27 is n or traun		19a. Informant's Name/Relationship (Type, Print) JEANETTE PITTMAN (SISTER)		-			City or Town, State, Zip. MARYLAND	
Baltimore,	iges 1 and of the it of He or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other plac	ce)	Date 2	20c. Location - City or T	own, State
턡	ntmer rtmer rtant njury							ALTIMORE, M	
Ba	Depa Impo any ii		21. Signatur Service Licenses JONATHAN	1				UNERAL HOME IMORE, MARY	•
	Pnysician /Medical Examiner	Q. 7)	23a. Part1. Enfer the disease, or complications that caused the shock of heart failure. List only one cause on each line. Immediate Eause (Final disease or condition resulting in death) Due to (or as a condition)	mal fi	ter the mode of dyir	wke (or respiratory arre		Approximate Interval Between Onset and Death
8760, <	cate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Final Indentyin Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the co	consequence of):	S CClu	Mic,	Anda	и	1090
9	t o se	/Med	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. Date of deliv	201
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	∃Ectopic pregnancy ☐ Other (specify)	,		Month	Day Year
S, D	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	es 2 No 3 ☐ Pro	the cause of death?
Record	The law ate has b page 2 s	Completed					24a. Was ar autops perform 1 Yes 2	y prior to co	opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one	θ)	
of V	S S	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing H	ome 5 Reside	nce 6 Other (Speci	ify)
o uo	dlng h. After fune		27. Manne of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	Year) 28b. Time of Injury	Wor	ryat rk? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	r Attenter deal	Certification:	o □ Outside G □ Could not be	/ - At home, farm, st (Specify)			28f. Location (Sti City or Town	reet and Number or Rur n, State)	ral Route Number,
	To the Hospital of within 24 hours af To the Funeral Completely filled in	edical C	29a. Certifier (Check only one) Medical Examiner: On the basis of e and manner state	xamination and/or ir	th occurred at the till estigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as a ate and place, and due t	stated. to the cause(s)
	thin 2 the omple	Med	one) and manner state 29b. Signature and title of certifier	BG.	29c. Licens	se number	25	9d. Date signed (Month,	Day, Year)
	F 3 F 8) ////////////////////////////////////	Was st.	·	1497	69	2/17/	n
				10 vysi C	Crist)		v (4131	UDIA
	2		30. Na and address if pere who completed cause of de-	(ttem 23a) (Type		611	1/12/1	No Rel A	1 /d 2 12 n
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar	SULV W s Signature	re my	7-66	0(1	1-1/4/12	4100 424
	Regist		FFB 1 7 2006	. M.	Locate)				

ORIGINAL

		•	Amend item#18,px 1- State Registrar	erist (35%) W		artment of H			giene 0 0 6	04743
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		ELIZABETH WHITF	IELD				Month FEBRUAR	NY 13, 2006	2:00p M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of E	Death	4c. County of Dea	
			JOSEPH RITCHIE			BALTI			N/A	
	Funeral		5. Social Security Number 6. S	ПМ 2ПЕ	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hours	Min. (Month, Da	y, Year) C	thplace (State or Foreign ountry)
	Director		231-14-4467 Usual Residence of Decedent	X	93	1		10-12-	-1912 NOR	TH CAROLINA
	ehow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man,	to	MD. N/A		BALTIMO	RE				1 XYes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	th wil	a C	4313 OLD YORK R	D.		2121	2		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, F	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Am Black, Whi	
36	or the	by Fu	1 Never Married 2 Married	1 Yes 2 X	No	1☐ Yes 2☐XNo	Specify:		Specify: B	LACK
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or iteme 23a or 28a-f ehow he Madical Examiner must be notillied at	8	3 Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a Dec	edent's Usual Occup	ation		16b. Kind of Business	s/Industry
15	n n	Completed	(Specify only highest gra	ide completed)	(Giv	e kind of work done of DO NOT use retired	during most o	f working		
212	d with	E O	Elementary/Secondary (0-12)	College (1-4or:		ANITORIAL			PUBLIC SC	HOOL
	be filed tal Hygie d other event, II	Be C	17. Father's Name (First, Middle, Last)				Name (First, Middle,	Maiden Sumame)	
/lai	Ments Ments brked	2	ELVIN MAYE				Lula Ma	ıye		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Heelih and Mental Hygiene. If Item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow or other treumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (1	•			er, City or Town, State,	Zip Code)
	1 and Heelth em 27 other tr		LARRY WHITFIELD	(SON)			E RD.	-	WARE 19701	
Baltimore,	permit. Pages 1 and 2 Department of Heelth s Importent: if Item 27 is eny Injury or other tre <u>once</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Oremation 3 ☑		20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. Location - City o	r Town, State
Ë	permit. Pages Department of Importent: If II eny Injury or c		4 Donation 7 Other (Specif			NT CEMETE			PHILADELPH	
Bal	permit. Departr Importe eny Inju		21. Signature of Funeral Service lio-	See JONATHA	1.09				UNERAL HOM	
	40300	-	23a. Part . Inter the disease, or com	0.770						YLAND 21217 Approximate
1	Priysician /Medical		sho k, or heart failure. List only Immediats Cause (Final disease of condition resulting in death)	a	wut	2009	M Cl		11031,	Interval Between
	Examiner			· ·	a consequence of):					1
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of).					
V	icate be executed physicien and s the buriat-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.						
o,	e exe ien au uriaf-t	EX	resulting in death) Last	Due to (or as	a consequence of):					
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9	death certific attending p	Me	IF FEMALE:	22- 14	4					
Вох	law requires thet the death certific as been signed by the atlending f 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
Ö	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death 5	Other (specify)				
_	n requires that the de been signed by the i should be detached	h h	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ds	uires Sign Id be	d by	Mutastas	us to	bone,	١.		10	Yes 2 No 3 F	Probably 4 Onknown
00	w req beer shou	Completed	Ploural	John	mim			24a, Was	an 24b Were a	autopsy findings available
Re	The la sete has page 2	Ĕ	100000		100 -				rmed? death?	autopsy findings available completion of cause of
Division of Vital Records,	siclan: The law certificete has t irector, page 2 s	Be C	25. Was case referred to medical				26 Place o	1 ☐ Yes 1 Death Check only o	-	s 2 No
<u>></u>	yaich is cer direct	To B	examiner? 1 ☐ Yes 2 © No	Hospital:	ent 2 ☐ ER/Outpati	ent 3 DOA Oth	or.	ing Home 5 Resi	1	outosmei
0	ig Ph ter th neral		27. Manne of Death	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injury	of 28c. Injur	y at	28d. Describe	how injury occurred	
0	auth. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investigation	n	,,		Yes 2 □ No			
i≥	r Atte	Certification;	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm, stc. (Specify)	treet, factory, office	7,5-17,	28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	ital o irs aft rel Di led in									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ical	(Check only 2 Medical Exa	miner: On the basis o	of examination and/or	ith occurred at the th nvestigation, in my o	ns, dats and ppinion, death	place, and due to the occurred at the time,	date and place, and du	ue to the cause(s)
	thin 2 the I	Medical	29b. Signature and title of certifier	and manner st	ated.	29c. Licens			29d. Date signed (Moi	
	N N S	_		M/		250. 200115	2710	m	7/10	101
	-		7001)	oomploted as	death (New OC) \ T	Dailer)	100	00	0/13	100
	3		30. Name and add as of person who	completed cause of	death (Item 23a) (Type	(1) Dell.	1 Qt	Bait	11. NO	M2125
	St	ate	31. Date filed (Month, Day, Year)		rar's Signature	A A	, / ,	7000	A NOW A	
	Regist		FFB 1 7 2	0006	was At 1	Could				

		1	For State Registrar	Sta			•		t of H	ealth a	and M	lental Hyg	iene	006	047	
			Decedent's Name (First, Middle	e, Last)						-		2. Date of Deat	h		3. Time of	Death
	Physicia /Medic		Thelma Eliza	abeth V	Veems							February	Day 12,	2006	4:10	P^{M}
ì	Examin	_	4a. Fecility Name (If not institution	n, give street a	and numbe	er)		4b. City,	Town, or	Location	of Death		4c. Co	ounty of Deat	h	
			Ridgeway Manor	r Nursi	ing H	ome				ville				altimo		
ľ	Funeral	9	5. Social Security Number	6. Sex			last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birt	hplace (State o	x Foreign
Ш	Director		215-01-2040 Usuel Residence of Decedent		24	92	Yrs.					July 07.	1913	Mai	ryland	
	and		10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Mary f ehc	ō	MD Pol-	timore			Cator	orri 1	10						1 ☐ Yes	2 <u>10</u> No
	28a	Director	MD Bal	LIMOLE			Cator	10f. Zip				1	0g. Citizer	n of What Co	untry?	
	be filed within 72 hours after death with the Maryland nia! Hygiene. bd other than "nature!", or Items 23a or 28a-1 ehow event, it a Medical Exactinar must be notified at	<u> </u>	421 Neepier R	oad					21	228				ISA		
	death ms 2	Funeral	11. Marital Status	12. Wa	s Decede	nt Ever in U	.S. 13. \	Vas Deced	tent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Ame		
Þ	after or Ite		1 Never Married 2 Marr	ied 1	ned Force]Yes 2['es. Give			Tes, spec I∐Yes :				nican, etc.)		Black, White Black, White Black, White	e, etc. hite	
3	be tited within 72 hours after lal Hygiene. Id other then "naturel", or Ite event, the Medical Examina	d by	3 XWidowed 4 □Divorced		ar or Date	s:			20110	эрвину.			34	oechy: WI	1110	
ก็	72 h "natu	Completed	15. Deceden (Specify only highe		oleted)		16a. Deced	kind of wo	rk done d	durina mos	st of work	ing	16b. Kind	of Business/	Industry	
V	within	d m	Elementary/Secondary (0-12)	Co	llege (1-4d	or 5+)		omema.)			Own	Home		
7	e filed within al Hygiene. I other than 'vent, tre Me	e Co	8 17. Father's Name (First, Middle,	Last)			110	Jiii Sili Ci.	KC1	18. Mothe	er's Nam	e (First, Middle, M				
yland	d be antal	8	Joseph McC		le							oretta (
	should be nd Menta marked imatic ev	္ပ	19a. Informant's Name/Relations				19b. Mailir	g Address	(Street a			al Route Number			Zip Code)	
N N	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic esons.		Walter W. Weem		So	n		-				Cooksvi	-			
ō,	s 1 ar f Hea f Hea othe		20a. Method of Disposition			1 0	Place of Dispo	sition (Nan	ne of					tion - City or		
baltimor	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S		II from Sta	ite	ke Viev			1	2-16	-2006	Svkes	ville	, Maryl	and
3	mit.		21. Signature of Funeral Service	-							y Ste	rling-As	hton	-Schwa	ab-Witz	ke
Ď	permi Depa Impo eny is		Check	C. C	K	1		inera 630 I	Edmor	ome o ndson	i Ave	rling-As tonsvill nue; Cat	le, i consv	nc. ille,	MD 212	28
-			23a. Part1. Enter the disease, or shock, or heart failure. List	complications	s that caus	sed the deat	h. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory arre	est,		Approximat Interval Bet	ween
¥.	Physician		Immediate Cause (Final disease or condition		10	LANI		ACI							Onset and	
•	/Medical		resulting in death)	a	Due to (or	as a conseq										
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	pe #s	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that juicited exerts.	<i>l</i>	Jue to (or	as a conseq	uence of):									
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מם	equire en si ould	eted										1 □ Ye	s 2 🗹	Vo 3∏Pr	obably 4 🔠	Jnknown
ecoras	aw 1s b	ple										24a. Was a autops		24b. Were au	utopsy findings completion of c	available ause of
	Tr ate pag	Comple										perform 1 ☐ Yes 2	ned?	death?	2 No	
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	-							e of Deat	h (Check only on	e)			
5	S S =	P	1 Yes 2 No	Hospita	1 UInpa		ER/Outpatier			4 GN	ursing Ho	ome 5 Reside			city)	
		lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	g	. Date of I	Day Year)	28b. Time of Injury	M 2	8c. Injury Work	k?	INIO.	28d. Describe ho	w injury o	ccurred		
UNISION	Attending rt death.	cat	2 Accident investig	not be	Place of	Injune - At he	ome, farm, str			Yes 2 🗌	INO	28f. Location (St	reet and h	Jumber or Ri	ura I Boute Num	hor
2	after after Direction by	Certification:	4 Homicide determ	ined 200		etc. (Specif		eer, ractory	, once			City or Town	, State)	voiliber or ric	arar riodi g ridii	Der,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician:	To the be	st of my kno	wledge, death	occurred	at the tim	ne, date ar	nd place,	and due to the ca	ause(s) an	nd manner as	s stated.	
	P Ho	Medical	(Check only 2 Medical one)	Examiner: O	n the basis id manner	s of examina	tion and/or in	vestigation,	, in my op	pinion, dea	ath occur	red at the time, d	ate and pl	ace, and due	to the cause(s	;)
	To th within To th comp	Me	29b. Signature and title of certifie	1	1			290		e number		2	9d. Date s	signed (Mont	h, Dey, Year)	
1			Dama	, E 15	Nr	hois	nu) 1		3//	_		2//	3/01	6	
	10		30. Name and address of person	who complete	ed cause o	of death (Item	n 23a) (Type,	Print)	19-M	DAN	E.	BLRC	N/P	SS No	0	
	l v		5411 040 PRE	DERA	A 1	2010,	SULTE		8	BLIZ	Smo	REMA	RYL	AND a	11229	
	Sta		31. Date filed (Month, Day, Year)		32 Regi	istrar's Signa	ture	antil								
	Registr	ar	FEB 1	2006	Des	ARI A	19									

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H rtificate of I			ene 0	5 ()4745
	Physici		1. Decedent's Name (First, Middle, Last)	Bushm	ian You	mZ		2. Date of Death Month	Day	Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give s Augsburg Lutheran	Home		Baltimo			4c. County o	f Death	
	Funeral Director		5. Social Security Number 6. Sex 217-38-3607 Usual Residence of Decedent	7. Age	e (In yrs. last birthday) 105 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 30	Year)	Cour	nace (State or Foreign ntry) nsylvania
Package 4	e-f show	ctor	10a. State 10b. County MD		10c. City, Town or L Baltimo					1	0d. Inside City Limits 1 Yes 2 No
4 4	23a or 28 ust be no	ral Director	10e. Street and Number 6811 Campfield Roa	ad		10f. Zip Code 21207		10	g. Citizen of W	hat Cour	ntry?
1215-0036	had tygiene. It has been then "naturel", or lieurs 23a or 28e-f show event. It is Medical Evaluating that be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	, White,	etc.
21215-0036	ane. than "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Give	dent's Usual Occupa kind of work done of DO NDT use retired	during most of wor i)	king	6b. Kind of Bus		dustry
7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	tal Hygi d other event.	To Be Co	12 17. Father's Name (First, Middle, Last) Strong Vincent B	4 Bushman	reg	istered n	18. Mother's Nar	ne (First, Middle, N			
	, E - 3	Total S	19a. Informant's Name/Relationship (Ty.) Thelma Jones/frien	•	200	ng Address <i>(Street a</i> Belmont Fo	and Number or Ru	ral Route Number,	City or Town, S		Code) 21093
בַּ	nent o		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Specify)	_	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	э)	Date 2	Oc. Location - C	ity or To	own, State
Bail	Depart Import any in		21. Signature of Funeral Prvice License Ranald S. V	lade Dir	ester S B	2. Name and Address tate Anat altimore,	omy Boar MD 212	01		re S	
	nysician /Medical ixaminer		23a. Part1. Enter the disease, or compliance shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	a consequence of):		,	correspiratory arre	Sī,		Approximate Interval Between Onset and Death
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	:	a consequence of):						
O YOU .	e attending phy	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont		ery Day Year
r į	n signed by uld be detac	leted by Ph	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	ınderlying cause givi	en in Part I.	23e. Did tob	_		ne cause of death?
I Records, P.O		Complete						24a. Was ar autops perform 1 Yes 2	pr ed? de	ere auto ior to cor eath? ☐ Yes	psy findings available inpletion of cause of 2 No
DIVISION OF VITAL RECORDS,		To Be	27. Manner of Death	lospital: 1 ☐ Inpatie 28a. Date of Injui	ry 28b. Time o	-	er: 4 Nursing H	ith (Check only one lome 5 Reside 28d. Describe ho	nce 6 □Other		y)
DIVISION	the	Certification:	1 Astural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		ury - At home, farm, si	M 1 🗆	Yes 2 □ No	28f. Location (Str City or Town	eet and Number State)	r or Rura	l Route Number,
- 6	t hours	Medical C	29a. Certifier (Check only one) 12 Certifying Physical Exemination (Check only one)	sician: To the best oner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	th occurred at the tin	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and man te and place, ar	ner as st	ated. the cause(s)
F	within 2 To the Complet	Me	29b. Signature and title of certifier	× ′		29c. Licenso	9 number D3757	7 56	d. Date signed Februa		Pay, Year)
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type Mark St	0 '	Herstown	MD	2113	6	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 7 20	63	ar's Signature	sike		, :			

State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) PEBRUARY Day 2006 09 430AM **Physician** Gloria June Rose Zimmerman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Union Memorial Hospital If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 21 F Sep. 8, 1928 <u>Maryland</u> 215-24-9565 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a State or then "natural", or Items 23a or 28a-f ehow the Madical Examiner must be notified at 1√XYes 2 No MD n/a Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 4200 Massachusetts Ave. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2m No Yes Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 No Specity: white Specify: white ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygjenn Important: If Item 27 Ie marked other the eny injury or other traumatic event. ITEM 2016. Home Homemaker 5th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lenoard Howard Newdecker Hester Mary May Schwarz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles W. Zimmerman Jr. Husband 4200 Massachusetts Ave. Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Feb. 13, 06 Baltimore City 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licentific 3620 Wilkens Ave. Baltimore, MD 21229 Approximate eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Ominut ardlac **Physician** disease or condition resulting in death) /Medical entialar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine o the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Corunary physician and that initiated events resulting in death) Last Due to (or as a consequence ol) Box 68760, Completed by Physician/Medical been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown estevemio 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 2 🗆 No After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural n 24 hours after death.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 T Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title February 09,2006 00063163 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Baltomere MD 21218 201 East Universit Nyvyen, M.O Varleway Stephen 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) ALFRED 2. Date of Deeth 3. Time of Death JOHN D'AMBROSIO _Month Year **Physician** :45 AL -e6 2006 ALFRED JOHN AMBROSE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Genesis Healthcare/Layhill Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1⊠ M 2□ F Yrs. Aug. 26, 1924 New York, Director 577.16.8868 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3609 Tarkington Lane 20906 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Naval Surface College (1-4or 5+)
2 Years Elementary/Secondary (0-12) Years Warfare Accountant Center 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ D'Ambrosio Regina Rose DeStefano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cecilia D. Ambrose/Wife 3609 Tarkington Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2/8/2006 Silver Spring, MD 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Vieneza 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. yorardial Infarction Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine attending physician end I for use as the burial-trensit To the Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No ۾ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been si Completed certificate has b director, page 2 s 1 ☐ Yes 2 ☑ No TLYSS ZKINO director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Yes 2√2 No I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Yes 2 □ No efter death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel C completely filled CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5-3642 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paugn Blv2.303 560 31. Date filed (Month, B 0 egistrar's Signature State 06 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 4, Physician Madeline Frances ANNIS 5:05p. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Williamsport Nursing Home Williamsport Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | | Dec. 29, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Dec. 1 ☐ M 2 🔂 F New York 053-07-8479 90 Yrs 1915 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Washington Williamsport Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 N. Artizan Street 21795 238 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If tam 27 is marked other transfer any injury or other transatic avantages. College (1-4or 5+) Elementary/Secondary (0-12) 0-12 bookkeeper distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward A. Murphy Mary Fallon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Spielman - daughter 37 Mealey Parkway, Hagerstown, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State February Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 6, 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 2174 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician tailure renal LYEOL /Medical Due to (or as a consequence of): Examiner mellitus diabetes ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 INO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Congestive Heart 1 Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 I rursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ №6 Medical Certification: To 27. Manner of Death 1 Watural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be 3 Suicide within 24 hours efter de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lertifying Physician: To the best of my knowledge ideath occurred at the thire date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuttrer Sards, no D47451 February 4, 2006 Williamsport Nursing Home, 154 North Artizan Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuthner-Sands ND William sport, Maryland 21795 31. Date filed (Month: Day, Year) 32. Registrar's Signature State Registrar

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		-	For State Registrar	State	of Ma	ryland	/ Depa	irtmei <i>tifica</i>	nt of H te of L	ealth ai D <i>eath</i>	nd M	ental Hy	giene Reg. Ne		6	04749
		. 5	1. Decedent's Name (First, Middle, Last,									2. Date of De Month	ath Da	ıv \	/ear	3. Time of Death
	Physicia		Helen Anspacher									January				10:30aMh
	/Medic Examin		4a. Facility Name (If not institution, give	street and n	umber)			4b. City	, Town, or	Location of	Death		40	. County of	Death	
		Capital Capital	Rockville Nursir	g Hom	e				ckvil				1	Montg		-
	Funeral		Social Security Number 6. Security Number		7. Age		st birthday)	If Unde Months	or 1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year</i>)	9. Birthp Cour	elace (State or Foreign etry) Souri
	Director		220-30-3133]M 2√2 F		9:	2 Yrs.					(Month, D	8, I	913	Miss	souri
	and w	-	Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	daryli sho	٥	Maryland Montgome	ry		Pot	omac									X□Yes 2□No
	28a-	Director	10e. Street and Number					10f. Z	ip Code				10g. C	itizen of Wh	nat Cour	ntry?
	with sa or		11614 Deborah Driv	0					0854				U.	S. A		
	seath	era	11. Marital Status	12. Was De	cedent E	ver in U.S	. 13. \	Was Dec	edent of H	ispanic Orig	in? (Spe	cify Yes or N	0-			ean Indian,
36	s after o	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed f 1 ☐ Yes If Yes, 0 Year or	aive N	0	Ì		ecify Cuba	Specify:	, Puerto I	Hican, etc.)		Specify:	, White, Wh	
우	hou	edi	15. Decedent's Edu	cation			16a. Deced	dent's Us	ual Occup	ation			16b.	Kind of Bus	iness/In	dustry
15	in 72	Completed	(Specify only highest grad				(Give life. i	kind of w DO NOT	rork done i use retired	during most f)	of workii	ng				
212	s with piene.	E	Elementary/Secondary (0-12)	2 1	(1-4or 5- ears	-/	Home	make	r				()wn Ho	me	
ᅙ	e filed I Hyg oths	BeC	17. Father's Name (First, Middle, Last)							18. Mother	r's Name	(First, Middle	e, Maide	n Sumame)	
/lar	Venta Venta Venta	ToE	Jacob Morris Kle	in								ie Her				
Maryland 21215-0036	d 2 sho th and 1 27 is ma trauma		19a. Informant's Name/Relationship (T) Lynne A. Spivak		ghte	r						l Route Numb				0854
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Menalle Hygiene. Department of Heatile and Menalle Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Example must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from		20b. Pla	ace of Dispo metery, crer	matani ai	other olar	ardens		22/06		Location C		
altin	ermit. Pa epartmer hportant ny Injury		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	99			22	2. Name	and Addre	ss of Facility	y ra N	femoris	1 C	hape1	s, I	inc.
10 m	205 20		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications tha	t caused	the death.	2-11	70 R	ockv	ille P	Pike	, Rocky	7 1 11	e, Ma	ryla	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	а Н	yper	tensi	ive He									Onset and Death
	/Medical Examiner		Tooling in addition		,	a conseque	ence of):									
*	À .	e	Sequentially list conditions,	b	emen o (or an	tia Tonesqu	er ee of):									
	ansit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_												
<u>,</u>	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due 1	o (or as a	a consequ	ence of):									
8760,	sicia Psicia e bur	dical		d												
68	tificat g ph) as th	ed								11107		1.00			-	
Вох	eath certifi attending for use as	an/N	23b. was decedent pregnant	23c. If yes, o		of pregnan		⊒Ectopic	pregnanc	,				23d. Date Mon		ery Day Year
	the death certificate be executed by the attending physician and ached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		griant at	time of de	_	Other (WOI	u i	Day Tour
0.	- 0 0	Phy	9 Unknown				Mineria Aba			an in Don't		23a Dio	Ltobacco	use contri	bute to	the cause of death?
	se un es	þ	Part II. Other significant conditions co Depression	to	geath bi	ut not resu	iting in the t	ındəriying	cause giv	ren in Farti.						bably 4 ∑Unknown
Vital Records,	as the same as the	ompleted	Anemia										opsy formed?	, d	rior to co eath?	opsy findings available ompletion of cause of
a		O								GC Dinon	of Donat	1 Ves		1	Yes	2□ No
<u> </u>	Physician: this certitic ral director,	Be	25. Was case referred to medical examiner?	Hospital:		- a m	ER/Outpatio	nt 2	Ott	205		me 5 ☐ Re	- 1/1/2	6 MOthe	r (Snec	rful
o	Phys ral di	7	1 ☐ Yes 2 ☑ No 27. Magner of Death		☐ Inpatie te of Inju		ER/Outpatie 28b. Time o		28c. Inju Wo			28d. Describ				(19)
on	ding Ih. After funer	to	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigation		onth, Day	y Year)	Injury	М		rk?]Yes 2∐I	No					
Division	If or Attending after death. Director: After d in by the fune	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pla	ace of Inju	ury - At hor c. (Specify	me, farm, st	reet, fact	ory, office			28f. Location City or T			er or Rui	ral Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completely tilled in b		29a. Certifier 1 X Certifying Ph (Check only 2 Medical Exam	iner: On the	a basis of	f examinat	wledge, dea ion and/or ir	th occurre	ed at the ti	me, date an opinion, dea	id place, ith occur	and due to th	e cause e, date a	(s) and mar and place, a	nner as ind due	stated. to the cause(s)
	To the P within 24 To the F complete	Medical	one)	and m	anner sta	ated.				se number						, Day, Year)
	with To	~	29b. Signature and title of certifier	1/	a	M		4						_		, 2006
	10		Nima		- 1)	non	7		DO(004733	O		J	anual	у 19	, 2000
			30. Name and address of person who Thomas V. Joseph	completed c	ause of d	leath (Item	23a) (Type Edmong	Print)	Drive	e, Sui	ite 2	207, Ro	ckv	ille,	Md.	20852
zpi-ti	, n e	ate	Thomas V. Joseph 31. Date filed (Month, Day, Year)	32	2. Redistr	ar's Signat	lura	A	K A	,						
	Regist	ate rar	FEB 03	2006	A Real	were.	ture A	HORM								

			1- For State of Maryland / Dep	artment of Health and M rtificate of Death	Reg	one 006 04750
s _{ij}	Physicia	an	Decedent's Name (First, Middle, Last) CAMULTI	TINY	2. Date of Death Month	Day Year
4	/Medic	al	SAMUEL AS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JANUARY	23, 2006 8:39 A M
*	Examin	er	4601 N. PARK AVENUE #816	CHEVY CHASE		MONTGOMERY
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birthplace (State or Foreign Country)
139	Director		161-14-7445 Pusual Residence of Decedent		08/24/19	
	iryland show		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 ★ Yes 2 No
	289-1 1	ecto	MARYLAND MONTGOMERY 10e. Street and Number	CHEVY CHASE	100	g. Citizen of What Country?
	3a or	Funeral Director	4601 N. PARK AVENUE #816	20815		U.S.A.
	deeth	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28e-f show tha Marical Examinar must be mailled at	by Fu	1 □ Never Married 2 ሺ Married 1 ሺ Yes 2 □ No ff Yes, Give WWII 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify: WHITE
21215-0036	2 hour	ted t	15 Decedent's Education 16a Dec	edent's Usual Occupation e kind of work done during most of work	ing 1	6b. Kind of Business/Industry
215	ithin 7 ne. ne.	Completed	Elementary/Secondary (0-12) Cotlege (1-4or 5+)	DO NOT use retired)		
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)	PHYSIOLOGIST 18. Mother's Nam	e (First, Middle, M	PLANT aiden Sumame)
au	id be ked o	To Be	HARRY ASEN	RACHEL		LEIBMAN
Maryland	2 should the and Meni Is marked sumatice	15		ling Address (Street and Number or Rui N. PARK AVENUE #81		CITA CE MADVI AND
	Health Fm 27		20a Mathad of Disposition 20b. Place of Disp	position (Name of		Oc. Location - City or Town, State
TOL	Pages 1 nent of H any or oth		1 Ki Ruriat 2 Compation 3 Removal from State	ematory or other place) [EMORIAL GDNS 01/25	5/2006 0	LNEY, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Marical Examinat must be notified at once.			22. Name and Address of Facility DANZANSKY-GOLDBERG	MEMORIA	L CHAPELS, INC.
	805 20		23a. Part 1. Enfer the disease, or complications that caused the death. Do not e	1170 ROCKVILLE PIE	E ROCKV	TIE MARYLAND 20852
			shock, or heart failure. List only one cause on each line.		,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. CONGESTIVE HEART Due to (or as a consequence of):	FAILURE		
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. RENAL FAILURE Due to (or as a consequence of):			
	ned nsit	Examiner	Cause (Disease or injury			
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	ate be physici the bu	dicai	d			<u> </u>
89 x	death certificat e attending phy d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
. Box	0 0 0	Physician/Med	in the past 12 months? 1 Yes 2 No	□ Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	that the de ed by the detached	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
ds,	Se us	d by		and onlying cause grown and an arrangement	1 □ Ye	s 2∭No 3☐ Probably 4 ☐Unknown
Records,	aw requir as been si 2 should	ompleted			24a. Was ar	
Re	he ha	Com			perform 1 □ Yes 2	ned? death?
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner? Yang and No. 10 September 2015 Provinces and September 2015		th Check only one	
of	Phys r this ral di	. To	The res 2 No 1 Impatient 2 Envotipat	of 28c. Injury at	28d. Describe ho	nce 6 □Other (Specify) w injury occurred
ion	£ 2 £ 5	atlor	1X Natural 5 investigation (Month, Day Year) Injury	M 1 Yes 2 No		
Division	or Attency after death Director:	Certification:	3 ☐ Sy ide 4 nomicide 6 ☐ Could not be determined 29 . Place of (njury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Sti City or Town	reet and Number or Rural Route Number, , State)
	To the Hospital or within 24 hours after To the Funerel Direction Completely filled in b			ath occurred at the time, date and place	, and due to the ca	ause(s) and manner as stated.
	he Hoin 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, da	ate and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number D030247		9d. Date signed (Month, Day, Year)
	20		30. Name and address of person who completed cause of death (Item 23a) (Type		J	ANUARY 24, 2006
			DR. ALAN R. MORRISON, 5410 CONNECTION		103, WAS	HINGTON, DC 20015
		ate	31. Date filed (Month, Day, Year) FEB 0 3 2006 32. Bigistrar's Signature			
14	Regist	aren.				

			1 ← State Registrar	State of Maryland / De	partment of Health and Nertificate of Death	Mental Hygie Reg.	tion of the table to	
	<u>.</u>		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death	_
	Physici /Medic		William	Thomas	Allee	February		V
in	Examin		4a. Facility Name (If not institution, give s	· ·	4b. City, Town, or Location of Death		4c. County of Death	
			Country House I		Cumberland		Allegany	
4	Funeral		5. Social Security Number 6. Sex 217-18-4495	M 2∏F	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		gn
	Director		Usual Residence of Decedent	84		10/21/19	21 Maryland	
	yland yland		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limit	s
	Mar B-fst	to	MD Allegan	у	umberland		1 ☐ Yes 2 ☒ N	0
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any righty or other traumatic event, the Nedical Eventual percelling at anothe.	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Country?	
		le l	13706 Bedfor	rd_Road, NE	21502		USA	
		Funeral	71. Walkar States	Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puent 	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc. 	
36	rs afte	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 (∑Yes 2 □ No If Yes, Give Year or Dates: WWTT	1 ☐ Yes 2 ☒ No Specify:		Specify:	
21215-0036	in 72 hour n "natural Vedical Ex	To Be Completed	15. Decedent's Educ	*****	cedent's Usual Occupation	161	White b. Kind of Business/Industry	
215			(Specify only highest grade Elementary/Secondary (0-12)	completed) (G	ive kind of work done during most of work a. DO NOT use retired)	ring	.,,	
2	d with giana ar tha		12	1	Machinist		Railroad	
ם	ould be file Mental Hyg arkad othe		17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	
<u>yla</u>			Wi ll iam	Henry Alle	e Mary	Thelma	DeVore	
Maryland	2 sh and Ism raum		19a. Informant's Name/Relationship (Typ	ne, Print) 19b. Ma	ailing Address (Street and Number or Rui	al Route Number, C	ity or Town, State, Zip Code)	
e o	1 and fealth im 27 thar t		Diana A. Beverlin 20a Method of Disposition		Rosehill Avenue,		d MD 21502	
altimore,	ages if its or of		1XXBurial 2 ☐ Cremation 3 ☐ Re	emoval from State cemetery, o	rematory or other place)			
Ħ	it. Partmer		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service License		-		Sumberland, MD	
Ba	permi Depa Impo any ir		1 + 1 (1		404 Decatur Street,		Funeral Home, P.A	•
	Pnysician /Medical		23a. Part1. Enter the disease, or complic	ations that caused the death. Do not			Approximate	
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1/-12 L	Disease	Interval Between Onset and Death	_
1			disease or condition resulting in death)	Due to (or as a consequence of):	Mzheimer +	UCHE	SyeAR	>
	Examiner		Sequentially list conditions b					
	cate be executed physician and the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
		Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760,		alE		Due to (or as a consequence or).				
	icate phys s the	edical	d					
×	eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery	
Box	death a atte	Iclai	in the past 12 months?	4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i>)		Month Day Year	
O.	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funaral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	hys	9 Unknown	9□ Unknown				
S. G		ру Р	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?	
ord						1 Tes	2 No 3 Probably 4 Unknow	n
Records,		Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	.0
		Con				performed 1 ☐ Yes 2 ☑	death?	
Vital		Be	25. Was case referred to medical examiner?	ospital:		h (Check only one)	Aggigted	
0	Phys this ral dir	Certification: To	1 Yes 2 No	28a. Date of Injury 28b. Time		ome 5 Residence 28d. Describe how i	e 6 NOther (Specify)	_
on	ding Phy th. After thi funeral o		1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No	Edd. Describe flow	injury coccined	
Division of	Attenor death	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,	street, factory, office		t and Number or Rural Route Number,	
	s afte	Cert	4 Homicide determined	building, etc. (Specify)		City or Town, S	state)	
	To tha Hospitat or At within 24 hours after o To the Funaral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowledge, de	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus	e(s) and manner as stated.	
	tha hin 24 the F	ledi	one)	and manner stated.				
	on Sitt	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)	
1	0/IVA		1/M/c	agenum	D22181	Fet	oruary 2, 2006	
-	n1.		30. Name indiad less of person who co	A	_{ee, Print)} Bishop Walsh Drive,	Cumberle	and, MD 21502	
	Sta	te	Gary L. Was	32 Registrar's Signature		, ddmbella	110 21302	
	Registr	- 011	FEB 0 2 2006	Beer St A	DENTE			

			1- State of Maryland State of Maryland		artment of Health and I rtificate of Death	Mental Hygie. Reg.	the day of the	04752	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature", or items 23e or 28e-f ehow eny injury or other treumatic event, the Madical Examiner must be multipod at once.		Decedent's Name (First, Middle, Last) CHARLES J. ASHLEY			2. Date of Death JANUARY 2	Bay 2006	3. Time of Death 06:20 A M	
			4a. Fecility Name (If not institution, give street and number) CHESTER RIVER MANOR		4b. City, Town, or Location of Death CHESTERTOWN		4c. County of Death KENT		
			5. Social Security Number 220-32-0492 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye JULY 24,	9. Birthp	lace (State or Foreign htry) MD	
9036			Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation		1	Od. Inside City Limits	
			MD KENT RO	CK HAI	L			1∭Yes 2☐No	
			10e. Street and Number 5690 MAIN STREET		10f. Zip Code 21661	10g.	Citizen of What Cour USA	itry?	
			11. Marital Status 1 Never Mamed 2 Marned 1 Never Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 Never Marital Status	13	Vas Decedent of Hispanic Origin? (S _I f Yes, specify Cuban, Mexican, Puerti	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: WF		
15-0			15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during most of work	king 16b	. Kind of Business/Inc	dustry	
212			Elementary/Secondary (0·12) College (1·4or 5+)		IIPS MASTER		SHIPPING	ł	
, Maryland 21215-0036			17. Father's Name (First, Middle, Last) GILBERT ASHLEY			ne (First, Middle, Maid FREEMAN	den Sumame)		
			19a. Informant's Name/Relationship (Type, Print) BEVERLY ASHLEY/WIFE	19b. Mailin 5690	g Address (Street and Number or Ru MAIN STREET, ROCK	ral Route Number, Cit K HALL, MD	ty or Town, State, Zip 21661	Code)	
Baltimore,			1 XBurial 2 Cremation 3 Removal from State	netery, cren	sition (Name of natory or other place) IAPEL CEMETERY 01,		Location - City or To		
Balt	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee Suit A. Welfenlein	FE 13	LLOWS, HELFENBEIN O SPEER ROAD, CHI	N & NEWNAM ESTERTOWN,	FUNERAL H	OME, P.A.	
P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed TS S S S S S S S S S S S S S S S S S S	ıer	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
		ledical Certification: To Be Completed by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deared 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year	
			Part II. Other significant conditions contributing to death but not result and for the Condionosce	ing in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?	
Division of Vital Records,			-			24a. Was an autopsy performed 1 Yes 2 X	prior to con death?	sy findings available apletion of cause of	
Vita			25. Was case referred to medical examiner? Hospital: Hospital:			h (Check only one)			
l of			1 Inpatient 2 EH/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify)						
Sior			1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No					
2			4 Homicide determined 288. Place of Injury - At nom building, etc. (Specify)	City or Town, State)					
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
)		Σ	29b. Signature and title of certifier		29c. License number Mcl - 0/703	6 11	Date signed (Month, D	ay, Year)	
)(1) grates		30. Name and aldress of person who completed cause of death (Item 23a) (Type. Print) Susank-Ross W.D., 516 Wishing for Hore Cles Langaria Mid 21626						
	Sta Registr			ar) 32. Registrar Signature					

			1- For Amend Item 24 Registrar	aSpec of Many loc	92,027 Ce	17/06thb rtificate of	lealth and I Death		ene () ()	6 0475	3
			1. Decedent's Name (First, Middle, Las	t)	-			2. Date of Death	Day	3. Time of Deat	th
н	Physicia			John Ervin	!	Boone	II	Month February	Day 1, 200	Year 06 10:40 A	м
	/Medid Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County of		
H			17627 Homewood Ro	ad		На	gerstown		Was	hington	
-	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)		Birthplace (State or Form Country)	reign
	Director		220-16-2393	ZXM 2□F 82	Yrs.	Months Days	Hours Min.	Septembe	r 10,	Pennsylvani	a
_	ס		Usual Residence of Decedent					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	ylan how		10a, State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Lin	nits
	Ma	ğ	Maryland Washingt	on		Hager	stown			1 □ Yes 2. X	No
	r 28	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of W	'hat Country?	
	3 m o	D	17627 Homewood	Road		21740-	-753 4		U.S.	Д.	
	filed within 72 hours after death with the Maryland Hygiene. sther than "neturel", or items 23a or 28a-1 show sht, the Medical Exam at must be mulfied at	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race	- American Indian,	
0	r ite	Ē	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ZYes 2 ☐ No				o Rican, etc.)	Black	k, White, etc.	
5-0036	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White	
Ō	2 ho	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Bus	siness/Industry	
7	n'n 7	ple	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor d)	rking			
2121	y the	E	12	2		Horologi	st		Clock	Repair	
g	Hyg othe	a)	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma			
Maryland	id be enta ked ked	0 0	John Ervin Bo	oone			Rae	Delawter			
5	shound Minar	-	19a, Informant's Name/Relationship (vpe, Print)	19b. Maili	na Address (Street	and Number or Ru	ıral Route Number, (City or Town. S	State, Zip Code)	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or items 23a or 28a-1 show appringuty or other traumatic event, the Madical Examinat must be notified at ance.		Pansy J. Boone	(Wife)						and 21740-75	34
စ်	1 ar Hea Hem		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of	1			City or Town, State	
more,	Pages nent of I int: If its iry or o		1 Burial 2 XCremation 3	Hemoval from State	-	matory`or other plac	, I CDI	uary 3,			7
altin	rtan	1.7	4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen			g Cremato 2. Name and Addre				urg, Marylan	a
Ba	Department Department of the police of the p		21. Signature of Fulleral Service Licen				•			uneral Home	2
			Jette Lee.	Davis Mol			-			aryland 2178	3
Į,			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on sich line.	in. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arres	it,	Approximate Interval Between	
	Physician :	0 10	Immediate Cause (Final disease or condition	a Canc	V	40	ruch	405		(wit	11
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	(1	1			
n	LAGITITIC!	L	Sequentially list conditions, if any, leading to immediate	b							
	od sit	ine	cause. Enter Underlying	Due to (or as a consec	quence of):						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
760,	e ex		Tooding in dodiny sadi	Due to (or as a consec	quence ot):						
376	The law requires that the death certificate be executed the sbeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical		d			· · · · · · · · · · · · · · · · · · ·				
9	eath certifica attending ph i for use as t	Physiclan/Med	IF FEMALE:						1		
Вох	th ce tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnancy	,			of delivery	
	that the death cer ed by the attendin detached for use	Sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of o		Other (specify)			Mon	ith Day Year	
о. О	at the	hy	9 🗆 Unknown								
	res tha igned be det	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did toba		bute to the cause of death?	
p	w require been si should l							1- Tes	2 □ No	3 ☐ Probably 4 ☐Unkno	own
Records,	aw re ss be 2 shi	ompleted						24a. Was an	24b. W	ere autopsy findings availa	able
	The lav te has	E						autopsy performe	<u>ad</u> ? de	rior to completion of cause eath? □ Yes 2□ No	OI.
Vital		C	25. Was case referred to medical				26. Place of Dea	ath (Check only one		165 2010	
>	ysici s cer direc	0	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5⊞Residen	ce 6 ∏Othe	r (Specify)	
0	무도등	i.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how			
0	ndin ith. :: Aft	10	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No				
Division of	or Attending Physicien: after death. Director: After this certifics in by the funeral director, p	ertification;	3 ☐ Suicide 6 ☐ Could not be	289. Place of Injury - At I	ome, farm, st	reet, factory, office				er or Rural Route Number,	
ō	el or A s after I Dire d in by	ert	4 Homicide determined	building, etc. (Speci	ועי)			City or Town,	State)		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	alC	29a. Certifier 12 Certifying Ph	ysician: To the best of my kn	owledge, deat	h occurred at the tir	ne, date and place	, and due to the cau	ise(s) and mar	nner as stated.	
	n 24 n 24 ne Fu	edical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	irred at the time, dat	e and place, a	nd due to the cause(s)	
	To the H within 24 To the Fi complete	M	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed	(Month, Day, Year)	
			Marilan	, 11 11/			2562	3 1	chara	2.20m	10
	'n		30. Name and address of person wife	completed cause of death (Ite	n 23a) (Type.	Print)		1	-120	1 -1 -0	- 0
	2		Frederic It	K255 111	M	11110 1	redu	I (en	run	Rel	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	2.		11.	40.11	۸. ه	
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				partment of Health and Nertificate of Death	lental Hygie	E 0 0 0	04754
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		RUBY D. BROWN		FEBRUARY		4:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 15435 Old Frederick Road	4b. City, Town, or Location of Death Woodbine		4c. County of Death Howard	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 1 F 95 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 29	ear) Cou	place (State or Foreign intry) arvland
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Md. Howard Woodl				10d. Inside City Limits 1 □ Yes 2 No
	h with th	al Dire	10e. Street and Number 15435 Old Frederick Road	10f. Zip Code 21797	10g.	Citizen of What Cou United S	*
336	be filed within 72 hours after death with the Maryland ntal Hygiene. so other then "neturel; or Items 23e or 28e-f show event, ite Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 4 Marr	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-003	within 72 hou ene. then "neture re Medical E	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work by DO NOT use retired) Secretary	ring 16t	. Kind of Business/li	,
	ould be filed Mental Hygis arked other atic event, II	Be	17. Father's Name (First, Middle, Last) William Davidson		e (First, Middle, Mai Nelson	Insuran den Sumame)	ce
Maryland	d 2 sho th and 7 Is m treum	То	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	iling Address (Street and Number or Rur 435 Old Frederick F	al Route Number, C		p Code) 21797
altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tro		1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, c	rematory`or other place)		Cockville,	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee Market H. Barker	22. Name and Address of Facility Muriel H. Barber P. O. Box 5038	Funeral	Home	20882
)	Physician /Medical		resulting in death)				Approximate Interval Between Onset and Death
58760,	icate be executed physician and sthe burial-transit	edical Examiner	Due to (or as a consequence of): Dehydrat Due to (or as a consequence of): Dehydrat Due to (or as a consequence of):	s,on			years
P.O. Box 6	ath certif titending or use a	Physician/Me		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the Pulmonary Hyper fension	underlying cause given in Part I.		co use contribute to	the cause of death?
al Records,		Completed	Congestive Heart Faile Seizure Disorder	ire	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Division of Vital	Attending Physician: The ir death. ector: After this certificate h. by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how i		%) Son's Hom∈
Divis	el or Attenos s after deatl st Director: ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funeret Directo completely filled in by the	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, de 2 ☐ Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the causered at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
)	with Tot	Σ	29b. Signature and title of certifier	29c. License number D002594	7	Date signed (Month,	Day, Year)
	·		30. Name and address of person who completed outse of death (Item 23a) (Type EVELYN D. JACKSON, M.D. 3416 C	e, Print)	LNEY, MD		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2006 32 Registrar's Signature	ierle			

State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 20 PM Physician RNOUD RVING BERBER +KBRUMEY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. | North | Days | Hours | Min. | August | 27,1931 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1☐M 2☐F 74 Director 579-40-8876 New York Usual Residence of Deceden the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 23a or 28a-f show MD Montgomery Silver Spring 1 Tyes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3210 North Leisure World Blvd. # 409 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Items eny injury or other traumatic event. It a Medical Exactional once. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ludwig Leah Joseph Berger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Neil Berger / son 2024 Carter Mill Way, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb.5, 2006 Falls Church, VA King David Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation & Opher (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc 21. Signature of Fyneral Privice Licensee 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4SPIRATORY **Physician** /Medical Examiner MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. DNOGSTIVE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 1 Yes 2 No 3 Probably 4 ☐Unknown PRTERIOSCIEROTIC Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2**XX**0 the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 X Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5 nd address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Americad #23a 1 - State per PHY.gc,2/7/06 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month CLIFFORD 2006 9:55 PM BLONT JANUARY 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 325 CARMODY HILLS DRIVE CAPITOL HEIGHTS PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 1958 Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 47 578-78-5494 Director FEBRUARY WASHINGTON, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No PRINCE GEORGE'S CAPITOL HEIGHTS MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 CARMODY HILLS DRIVE 20743 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th LABORER PRIVATE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QDCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES BLOUNT LONNIE COUCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 CARMODY HILLS DR. CAPITOL HEIGHTS, MARYLAND 20743 LONNIE BLOUNT/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 2/3/2006 ROCKVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart friture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANCREATIC /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 3 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed? Yes 25 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after dec. 1X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) D50457 FEBRUARY 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN CHIGBUE M.D. 7943 CENTRAL AVENUE CAPITOL HEIGHTS, MARYLAND 20743 31. Date filed (Month, Day, Year) State FEB 0 7 2006 Registrar

2. Date of Death

January 30, 2006

3. Time of Death

)	Examin
	Funeral Director
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, if a Marical Erander must be invitited as once.
	Physician /Medical Examiner
	dansit

1. Decedent's Name (First, Middle, Last)

ician dical	Michael Gerome Bennett				Januar	у 3 0 ,	2006	10:28 P M		
niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		h		unty of Death			
No. of Street	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	a de desirable ada a d	Takoma P	If Under 24 Hrs	8. Date of Birt		ntgome			
í r	212-58-5760 ^{1⊠M 2□F} 54	Yrs.	Months Days	Hours Min.	June 2	8, 19	51 Te	nplace (State or Foreigr untry) X a S		
	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	ation					10d. Inside City Limits		
ğ	Maryland Montgomery Silv	er Sp	ring					1X Yes 2 No		
Director	10e. Street and Number	•	10f. Zip Code			•	of What Co	,		
aiD	8701 Kodiak Drive		20903			Unit	ed Sta	tes		
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Moivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		Race - Amer Black, White pecify:			
	15. Decedent's Education	16a. Deced	ent's Usual Occupa	tion			of Business/I			
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	ond of work done done do NOT use retired)		King	ъ.				
200	4	Comp	uter Engi				vate			
Be	17. Father's Name (First, Middle, Last)				me (First, Middle,	Maiden Su	mame)			
ဥ	William W. Bennett, Sr.	10h 14-11-	Address (Street a	Doroth		- China T	our Ctata 7	in Contail		
	Dorothy S. Bennett (mother)		g Address <i>(Str</i> eet a Sudbury R							
	20a Method of Disposition 20b. Pla	ce of Dispos	ition (Name of		Date		tion - City or			
	1 Li Burial 2 N Cremation 3 Li Hemoval from State		atory or other place e Cremato		8/06	Belts	ville.	Maryland		
	21. Signature of Funeral Service Licensee		Name and Address	-	-					
	Indre Thompso	1	400 Georg					20012		
	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dying	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition									
	resulting in death) Due to (or as a conseque		· (ac							
	Sequentially list conditions, b.									
Cxamner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause (Disease or Injury	ence of):								
70	that initiated events resulting in death) Last Due to (or as a conseque	ence of):								
edic	0.									
sician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	leath 3 🗌	Ectopic pregnancy Other (specify)			230	d. Date of deli Month	very Day Year		
2	9 Unknown				as- Pida			the server of death?		
ģ	Part II, Other significant conditions contributing to death but not result	ang in the un	derlying cause give	n in Part I.		obacco use ⁄es 2□1		the cause of death? bably 4 \times Unknown		
eted					-		40 3 1 1	John Talentine		
ᇫ					24a. Was autop		24b. Were au prior to death?	topsy findings available completion of cause of		
Con					1 ☐ Yes	2 X No		2□ No		
Be	25. Was case referred to medical examiner? Hospital: Wall-patient QUESTING		2□ DOA Othe	r	ath (Check only o		7.0			
10	TITIES ZIX NO TX Inpatient ZII E	R/Outpatient 28b. Time of	3000	4 Nutsing i	dome 5 Resid			cify)		
cation	1 Natural 5 Pending (Month, Day Year)	Injury	28c. Injury Work M 1 □ Y	? 'es 2∐No						
flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom	ne, farm, stre					Number or Ru	ral Route Number.		
Certif	4 Homicide determined building, etc. (Specify)				City or Tov	vn, State)				
edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known on the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) an date and pl	nd manner as ace, and due	stated. to the cause(s)		
Me	29b. Signature and title of certifier	//	29c. License	number		29d. Date s	signed (Monti	n, Day, Year)		
	1.60/ 3/6		45	203		2-	-01-	2006		
	30. Name and address of person who completed cause of death (Item 2	23a) (Type, I			}					
0	DR. STEPHEN SMITH 1300	Piccar	d Drive-	Suite	02: Rock	ville	. MD	20850		
ate	31. Date filed (Month, Day, Year) 32 Registrar's Signatu	ire Age					,	_0000		
rar	FEB 0 6 2006	-	-							

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

10/	+	30. Name and address of ger on who					D3	1069			2-6-	2006
To the Fun completely	Medical	(Check only one) 2 ☐ Medical Exam 29b. Signature and title of certifier	iner: On the basis of and manner stat	examınatı	ion and/or inves	stigation,	, in my opir	nion, death oc number	ccurred at the tim	e, date an	d place, and du	e to the cause(s) th, Day, Year)
ours afte		4 Homicide determined 29a. Certifier 1™ Certifyin, Phy	building, etc.	f. my lenese	elector diceth o	- heaunn	at tha five	, date and pla	City or 1	own, State	a)	Jural Route Number,
h. After th funeral	Certification: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	M 2	Work?	at es 2 No	28d. Describ	e how inju	ry occurred	ecity)
Ø ₽	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🕍npatier	nt 2 🗆 £	ER/Outpatient	3□ DC			Death Check on Beath Check on Beath Check on Beath Be		6 □Other (Spe	ecify)
ete hes page 2	e Completed		LUNG						pe 1 ☐ Yes	topsy rtormed? 2 2 No	death?	utopsy findings availa completion of cause of s 2 🕅 No
been signed should be det	þ		OTALYSIS LUNG	t not resu	Ilting in the und	lerlying c	ause given	in Part I.	_ 10	Yes 2	X No 3□F	to the cause of death? robably 4 Unkno
by the atter ached for u	Physician/Med	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last c. SEVERE ATHEROSCLEROSIS Due to (or as a consequence of): d. DIABETES MELLITUS										
nding physicien and use as the burial-transit	dical Examiner											
Medical xaminer	er	resulting in death) Sequentially list conditions.	Due to (or as a	a consequ	ECUBITU	S UL	CER					
nysician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused one cause on each lin	10.	n. Do not enter	the mod	de of dying	, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Department important: I eny injury o		21. Signature of Fund Signature 1	>		22. 1	Name ar	nd Address	of Facility		ENKIN	IS FUNE	RAL HOME
0		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		a	lace of Dispositemetery, crema RYLAND	atory or c	other place	1	Date 0/2006		ocation - City o	r Town, State
ealth an 27 ie r		FREDDIE BAZEMORE			11608	CAN	DOR D		Rural Route Nui			
nd Mental I	To Be	JOHN H. BAZEMORE						LENORA	GARRET	T		
Hygien other th	e Con	17. Father's Name (First, Middle, Last)	2 yrs		MAINTE	ENAN		GINEER	Name (First, Mide		VERNMEN	T
e. an 'net Medica	nplete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	i+)	16a. Decede (Give ki life. Do	ind of wo	al Occupa ork done du se retired)	uring most of	working	16b. I	Kind of Busines	s/Industry
if Health and Mental Hygiene. Item 27 ie marked other than "neturel", or Items 23a or 28e-f ehow other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ⅓ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 1 Yes 2 N If Yes, Give Year or Dates:		REORCE		dent of His ocity Cubar 28 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Jerto Rican, etc.)	No-	Black, Wh	nerican Indian, nite, etc. BLACK
23a or	ral Di	11608 CANDOR DE	RIVE				721				itizen of What (Country?
28e-1e	rector	MD PRINCE G	EORGE'S	MI	TCHELLE		LE p Code			10- 0	ising of last as	1X Yes 2□
how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Lin
Funeral Director		240-04-0200	ex 7. Age	6 (In yrs.	last birthday) Yrs.		Days	Hours N	Ain. (Month,	Birth <i>Day,</i> Year EMBER	/ 5	irthplace <i>(State or For Country)</i> RTH CAROLI
		DOCTOR'S HOSPI					MAH	W11-1			PRINCE	GEORGE'S
Exami		4a. Facility Name (If not institution, give	<u> </u>			4b. City	Town, or	Location of D	rebra		5 200 c. County of De	
/Medi		JOSEPH W. BAZEM	ייוֹ ת									

			Please	Type or Print in E						-	
			1 - For State Registrar	State of Marylan		epartment of H Certificate of I		/lental Hy	gien Reg. N	000	04759
2		5	1. Decedent's Name (First, Middle, Las	t)				2. Date of De	aath Da	av Year	3. Time of Death
	Physici		Adelaide Elizab	eth Betts						1, 2006	1:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		40	. County of Deat	1
			Montgomery Genera	1 Hospital		Olney			M	ontgomer	·у
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. i	ast birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birtl	nplace (State or Foreign
	Director		577-26-0087	□M 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Υ	rs. Months Days	Hours Min.	Nov. 2	2,	922 Was	hington, DC
	P .		Usual Residence of Decedent								
	anylar	L.	10a. State 10b. County			or Location					10d. Inside City Limits 1 X Yes 2 □ No
	8e-f	cto	Maryland Prince G	eorge's Upp	er N	Marlboro					
	ith th	Directo	10e. Street and Number			10f. Zip Code				itizen of What Co	untry?
	ath w	- E	13534 Lord Baltim			20772-			U.S		
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Sp an, Mexican, Puerto	Decify Yes or No Rican, etc.)	o-	 Race - Ame Black, White 	
20	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify:	h + + 0
3-003p	72 hours after death with the Maryland naturel; or Items 23a or 28e-f show disal Examinations be indiffed at		15. Decedent's Ed		162	Decedent's Usual Occup	ation		16b I	Kind of Business/	hite
		Completed	(Specify only highest gra	de completed)		Give kind of work done of life. DO NOT use retired	during most of worl	king	100.	ting of business	industry
7 7	e filed within al Hygiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Во	okkeeper			Pr	ivate Bu	siness
_	Hyg Hyg other		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle			
	ental ked c	To Be	Willie Bowes				Mary Vin	ginia N	lona	со	
2	es 1 and 2 should be f of Health and Mental h f Item 27 is marked ot r other traumatic eve	-	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address (Street :					lip Code)
2	ith a		John W. Okrak - S	on	13	534 Lord Ba	ltimore H	lace, U	Jppe	r Marlbo	ro, MD 20772
ā,	Hea Hea Heam othe		20a. Method of Disposition	20b. P	lace of	Disposition (Name of crematory or other place		Date		ocation - City or	
банттог	ages ant of at: If I		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		incoln Ceme	1	7/2006	Bra	ntwood	Maryland
	artme ortar injur		21. Signature of Funeral Service Lices		L 11.	22. Name and Addres				ral Home	
ä	permit. Pages Department of h important: If Ite eny injury or ot		Vi broken 14	100			0.6				MD 20781
			23 Part1. Enter the disease, or comp	olications that caused the death	n. Done						Approximate Interval Between
	Physician	2	shock, or hear failure. List only immediate Cause (Final			- 0 1					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to for as a consequence	Jence o	Infacto	14				
	Examiner										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ence o	t):		, , , , , , , , , , , , , , , , , , ,			
	executed in and ial-transit	Examin	that initiated events	c							
Ď,	be exe icien a burial-t	I Ex	resulting in death) Last	Due to (or as a consequ	neuce o	f):					
08/0	eath certificate be executed attending physicien and for use as the burial-transit	Ilca	•	d							
	certificate nding phys	Physician/Medica	IF FEMALE:								
Z D D	ath ce Itend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death	3 Ectopic pregnancy	,			23d. Date of deli	very Day Year
	e death he atten	scl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath	5 Other (specify)				WOTH	Day . oa.
Ţ.	that the ed by th detache	Phy	Part II. Other significant conditions of	ontobuting to death but not rec	ulting in	the underlying cause any	on in Part 1	23e Did	tobacco	use contribute to	the cause of death?
Š	w requires that the de been signed by the should be detached	by	Previous	orthodising to death out not rest	and ig in	the driderlying cause give	on arranti.		Yes 2		obably 4 domknown
ecoras	requires sen sign hould be	Completed	Premona Achlemia								
e S	S S	npl	- Ackenia					24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
<u></u>	Th ele pag	Col							2 N		2 No
VItal	ysician: Th is certificete director, pag	Be	25. Was case referred to medicat examiner?	Hospital:		Oth	26. Place of Dea				
0	Phys this al di	_T	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Out 28b. Ti	patient 3 DOA Oth	4 🗆 Hulanig in	ome 5 Res		6 □Other (Spec	cify)
	ler Ter	lon	1 €Natural 5 ☐ Pending	(Month, Day Year)		tury Wor	yat k? Yes 2 □ No	Zod. Describe	HOW IN	ary occurred	
DIVISION	Attending ir death. ector: After by the fune	cal	2 Accident investigation 3 Suicide 6 Could not be		me lar		103 2 110	28f Location	(Street a	nd Number or Ri	ral Route Number,
_	after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specifi		m, street, factory, office		City or To			14, 7,00,00,000,
_	spita ours serai filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge.	death occurred at the tin	ne, date and place	and due to the	cause(s) and manner as	stated
	To the Hospital or Attendir Whin 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and	or investigation, in my o	pinion, death occu	rred at the time,	date ar	nd place, and due	to the cause(s)
	To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. D	ate signed (Monti	n, Day, Year)
	(1)		1 Clearly	sepus		DE	39793		Fe	breasy :	2,2006
	Chin		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)					
	MC		Christopher J. Ma	45, mb 18111	PIN	ice Philip 1	de. Olus	y, les	0 2	0832	
	Sta		31. Date filed (Month, Day Year) FEB 0 7 2000	32. Registrar's Signa	ture	,					
324	Registr	ar	LEBA (7000	1 10							

			For State Registrar	State of Ma		partment of F e <i>rtificate of</i>			giene 06	04760
I	Physici /Medic			aret 10	Puser			2. Date of Dea Month O Z	Day Yea	
	Examin		4a. Fecility Name (If not institution, Anne Arundel Me 5. Social Security Number	dical Center	(In yrs. last birthda	Annapoli	S If Under 24 Hrs.	8. Date of Birt	Anne An	run de 1
	Funeral Director		214-46-1150 Usuel Residence of Decedent 10a. State 10b. County	1□M 2QF 9		Months Days	Hours Min.	July I	3 1913 Ann	country apolis, MD
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28e-1 show the Modical Extenditor in that be coulded at	by Funeral Director	MD Anne Anne 5 Rickover Co	Arundel ourt	Annapoli	10f. Zip Code 21401			10g. Citizen of What	
0036	hours after dea ural', or Iteme al Extenituer or	d by Fune	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	o	1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	pecify Yes or No Bican, etc.)	Black, Wi	hite
Maryland 21215-0036	filed within 72 Hygiene. ther then "net int, the W. Jr.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	College (1-4or 5-	(Gi	cedent's Usual Occupive kind of work done DO NOT use retire	during most of worl		Heal thea Maiden Sumame)	
ıryland	should be 1 nd Mental I marked of imatic svei	To Be	Charles Basil	l Gates	19b. Ma	ailing Address (Street	Lulu	Mitchel!	,	, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-1 show any injury or other treumatic event, the Modical Examiner man be motified at once.		Margaret B. Ta 20a. Method of Disposition 1 △ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp 21. Signature of Funcial, ervice)	aylor, Daugh	ter 5 R 20b. Place of Discemetery, c Cedar B	sposition (Name of rematory or other pla Sluff Ceme 22. Name and Addre	tery 02-	apolis, ^{Date} 06-2006 hn M. Ta	MD 21401 20c. Location City Annapoli aylor Fune	or Town, State
To No.	Physician /Medical Examiner	8 1	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	the death. Do not e.	enter the mode of dyir				Approximate Interval Between Onset and Death Once week
8760,	icale be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Decade or April 1 that initiated events resulting in death) Last	c. Due to (or as a Due to (or as a d.	Due to (or as a consequence of):					
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	/		23d. Date of d Month	lelivery Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant condition	ns contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.			to the cause of death? Probably 4 Punknown
Vital Records,		e Completed	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	rmed? death	autopsy findings available o completion of cause of ? es 2 \sum No
DIVISION OT VI	ding Phys n. After this funeral di	To B	examiner? 1 Yes 2 140 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	ation	y 28b. Time	of 28c. Injury	er: 4 ☐ Nursing Ho	ome 5 Resid	dence 6 Other (Sp now injury occurred	pecify)
DIVIS	vitel or Attandurs after death	Certification:	3 Suicide 6 Could no determin	building, etc.	. (Specify)	street, factory, office		City or Tow		
	To the Hospitel or within 24 hours after To the Funerel Dil completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the best of caminer: On the basis of and manner state	exam/nation and/or	29c. Licens	e number	red at the time, o	date and place, and d 29d. Date signed (Mo	nth, Dey, Year)
			30. Name and address of person w	tho completed cause of de	ath (Item 23a) (Typ	Pe, Print)	5/8/9	T	2/02	12006
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 3 20	100	r's Signature	132 H	11100	1 54	7 241. A	mgn h-M2

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ALTON EMANUEL BROWN FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth MAY 29, 1936 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1**X** M 2□F 216-30-3837 69 Director Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County notified at Director MARYLAND CHARLES INDIAN HEAD the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4135 GWYNN BROWN PLACE / P.O. BOX 193 20640 UNITED STATES Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1950
If Yes, Give 1050 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1955 1X Never Married 2 ☐ Married 10 Maryland 21215-0036 1 Yes X No Specify: Specify: þ 1959 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12TH GRADE College (1-4or 5+) BOILER OPERATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt tment of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Be JAMES FRANCIS BROWN BERTHA THERESA GWYNN BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DWAYNE M. CAMPBELL / SON 2365 WALBROOK COURT, WALDORF, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State rtment ST. CHARLES CEMETERY FEBRUARY 11,2006 GLYMONT, MARYLAND ¹ 4 □ Donation 5 □ Other (Specify) permit.
Departr
Imports
any inju 21 Strutture of Funeur Service Centre 22. Name and Address of Facility
THORNION FUNERAL HOME, P.A LYDIA C. THURNION JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prosician mota stali /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of):

Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 20 No 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) d title of certifier 06 ving D-52919 ango 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

3:37

10d. Inside City Limits

1 ¥Yes 2 No

9. Birthplace (State or Foreign

Year

CHARLES

MĂŘŸĹAND

BLACK

2006

requires that the death certificate be executed Box 68760. as use ŏ o detached Records, page 2 Vita funeral director, ō Division after death. Director: A the 1 in by Hospital within 24 hours fo the Funeral completely

> State Registrar DHMH 17 Rev 1/2001

JAMES

I.

31. Date filed (Month, Day, Year)

HARRING MD 102 CENTENNIAL ST STE 102 LAPLATA MD 20646

30. Name and ddress of person who commed ause of wath (Item 23a) (Type, Print)

FEB 0 7 2006

32. Algistrar's Signature

State of Man

yland / Department of Health and Menta	ıl Hygiene	
Certificate of Death	_ ~ 000	

		1	For State Registrar	Cei	rtificate of De			eg. No.	Jb	04/02
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Josephus Lee Bar	ksdale				31, 200		1455 P M
	Examin		4a. Facility Name (If not institution, give street and nur	nber)	4b. City, Town, or Lo	ocation of Death		4c. County	of Death	
		ш	PRINCE GEORGES HOSPITAL	CENTER	CHEVERLY			PRI	NCE G	EORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		5/9-24-2036	82 Yrs.			Dec. 5,	1923	Owin	gs, S.C.
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	anyla •ho	5	D.C.	Washing						1√2 Yes 2 □ No
	78a-f	Director	10e. Street and Number		10f. Zip Code			l 0g. Citizen of	What Coun	tn/2
	with	급								
	e 23	Funeral	1634 F. Street N.E.	edent Ever in U.S. 13.	20002	anic Origin? (Spe		Jnited	State oe - Americ	
	ltem Item	Ľ,	Armed Fo	rces? 2 N5/19/43	Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)		ck, White,	
5	rs af	by F	It Yes Go	ates:7/7/45	1 ☐ Yes 2 反 No	Specify:		Specia	y Blac	k
9500-61212	be filed within 72 hours after death with the Maryland at bygiene. de thygiene. de other than "naturel", or iteme 23a or 28a-f ehow event, I to Maulcal Exactions must be notified at	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	on		16b. Kind of B	lusiness/Ind	dustry
<u>.</u>	nin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give	kind of work done dur DO NOT use retired)	ring most of worki	ing			
7	iene r the	ē	8		Clerk			Priva	te	
_	m - 0 5	Bec	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	(First, Middle,	Maiden Sumai	m <i>e)</i>	
<u>a</u>	fental l	To B	Theodore Barksdale			Effie M	iller			
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, Ite M.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and			-		Code)
Σ	alth a		Joyce Butler / Sister	2307	-32nd Stre	eet S.E.	Washing	gton, D	.C.	20020
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tem 27 Is marked any injury or other traumatic ev once.		20a. Method of Disposition	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place)	C	Date	20c. Location	- City or To	wn, State
Ë	Page nent can int: If		12 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Lincoln M	lemorial	Feb.6	,2006	Suitla	nd, M	d.
= =	mit. partn ports y inju	1	21. Signature of Funeral Service Licensee	22	2. Name and Address	of Facility	Funaro	Loman	DΛ	
n	88 E 8 8		1 But france	2105	Name and Address Alexander 5538 Marih	ooro Pik	e/Forest	ville,	'Mā:A	20747
п			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on a	aused the death. Do not ent	er the mode of dying,	such as cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final	stage renal d						Onset and Death
	/Medical		resulting in death) a. Due to	(or as a consequence of):						-
	Examiner		Sequentially list conditions b							
		ner		(or as a consequence of):						
	rtificate be executed ng physicien and as the burial-transit	Examiner	that initiated events							
o	exe en ar urial-t		resulting in death) Last Due to	(or as a consequence of):						
68760,	ite be nysici ne bu	Medical	d							
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Box	eath cer attendir I for use	an/	23h Was decedent pregnant 23C. If yes, ou		Ectopic pregnancy				ate of delive onth	Day Year
	e des the at	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unkn		Other (specify)					
о. О	The law requires that the death ce ste has been signed by the attendi page 2 should be detached for use	Physician/i	Part II. Other significant conditions contributing to d	noth but not cogniting in the u	a dorbita a course auros	in Dort I	23e Did to	hacco use con	tribute to th	ne cause of death?
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20	w require been si should t	Completed	y Nea Caraco	19 Stry			(17=		0	
ec	e law has b	Jdu					24a. Was a autop	sy	prior to cor	psy findings available mpletion of cause of
<u> </u>	The Sete h	Con					perfor 1/2 Yes	med ? 2 □ No	death? 1 2 Yes	2 No
/ita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death	h (Check only or	ne)		
\leq	hysi this c	ပ္	A	Inpatient 2 XER/Outpatier		4 Nuising no	me 5 Resid			y)
Ĕ	ding P	io)	yap ratural	of Injury th, Day Year) 28b. Time o Injury	Work?		28d. Describe h	ow injury occu	rred	
Division of Vital Records,	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			s 2 No	COA Landing (C	· · · · · · · · · · · · · · · · · · ·		18-1-11-1-1
<u>></u>	l or Attendent efter deatl Director; I in by the	Certification	determined 208, Place	of Injury - At home, farm, st ing, etc. (Specify)	геет, тастогу, опісе		City or Tow		oer or Hura	I Route Number,
	Hospital 24 hours e Funerel I		278 Certifler 1 Certifying Physician: To the	a heart of your knowledge intent	h necessaries as the re-	data and elem-	and dustrible	Strangfat and	arres as a	ntad.
	To the Hospital or Attending Physician: The within 24 hours elter death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: On the b	asis of examination and/or in ner stated.	vestigation, in my opin	nion, death occurr	red at the time, o	date and place	and due to	the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier		29c. License r	number		29d. Date sign	ed (Month,	Day, Year)
	⊢s⊢ö		1 AND DM = D	A, m	0.C.	.M.E		FEB.	1, 2	006
	2111		30. Name and address of part on who completed and	se of death (Item 23a) (Type.	Print)					ements of the fields
-(Iva		Talha 2 areensers M.		N STREET,	BALTIMO	RE,MARYI	JAND 21	201	

State Registrar

31. Date filed (Month, Day, Year)

32. Regi 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

FEB 0 3 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth Year Physician arnes CRTHUR /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ings Prince YEORGES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days WasH., D.C. Director Usual Residence of Decedent permit. Pagas 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: if item 27 is marked other than "naturel", or items 23e or 28e-f show injury or other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Unitea Funerai Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) UTTER TH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code) 20174 19a. Informant's Name/Relationship (Type, Print) UPPERMON/DOD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01178 envu Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse in each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner ete has been signed by the ettending physician and paga 2 should be detached for use as tha bunal-transit The law requires that the death certificets be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3€ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this cartificete has 1 ☐ Yes 2 ☐ No 1∐Yas 2XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) Certification: To 1 ☐ Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending investigation 1 Tes 2 No deeth. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or A within 24 hours aftar To the Funeral Direct 29a. Certifier Medicai reartifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified death (Item 23a) (Type, Print) who completed cause 30. Name and address of person ctren

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day,

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ORIGINAL

Registrer's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Celester Vance B1ake 7:20 P. M January 26, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HCR/Manor Care Health Services Wheaton Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth | 9. Birthplace (State or Foreign (Month, Day, Year) | 918 | 9. Country) | 5 Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F 87 Yrs. 349-16-9596 Georgia Director November 5, Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r then "netural", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Director District of Columbia Washington 10e, Street and Number 10g. Citizen of What Country? 10f. Zin Code 717 Somerset Place, N. W. 20011 United States Funeral within 72 hours after death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper Domestic 10th grade t of Health and Mental Hyg If Item 27 Ie marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 99 Julian Vance Marie Sumlin Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 717 Somerset Place, N.W.; Washington, D. C. 20011 Marie Blake 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Feb.3,2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment o Important: If eny injury or once. Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee R. N. Horton Company Morticians, Inc. Xandalpl 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) caldio-Respiratory arrest **Physician** /Medical Examiner cerebrovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2Ba. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) H. D D0055362 January 30, 2006

The sen of Rockville HD 2085 30. Name and

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Bertha Bowe 7:15pM 02 01 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Laurel Mariner Health Care Of Laurel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/06/1900 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2**X** F Maryland Director 105 225-07-3643 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r then "neturel", or items 23a or 28a-f shov the Maulcal Exactiver must be notified at 1 Yes 2 No Director Md Prince George Laurel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20707 USA 14200 Laurel Park Drive Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 【No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private other then Housewife 12th s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other t other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mariah Williams Arthur Snowden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 is other tra 9347 Cabot Ct Laurel, Maryland 20707 Grandson James Bowe Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorsey Chapel Date it. Pages 1
sertment of H
portant: If Its
sy injury or c 20a. Method of Disposition 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) 2/8/06 Glendale, Md permit.
Depertu
Imports
eny inju 22. Name and Address of FacilitySnead Mortuary Service, PA 21. Signature of Funeral Service Licensee 1409 Fairlakes PL Ste B Bowie, Md 20721 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, as a second of the sequence of t Physiclan/Medical Examiner Due to for as a consequence of rsician and e burial-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Arteriosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? 2**X** No 2□ No 1 Yes 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Sign 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 XNatural 5 🗀 Pending after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/02/06 D24721

State Registrar 14333 Laurel Bowie Rd Suite 208 Laurel, Md 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Sayeed Sadiq M.D.

FEB 0 3 2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Rosella Elizabeth Brinkman January 22. 2006 16:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany County Nursing and Rehab Ctr. Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗓 F Hours Yrs. Director 220-10-7544 89 11/13/1916 Maryland Usuel Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location in then "naturel", or Items 23e or 28a-f ehow The Medical Exemples must be notified at 10d. Inside City Limits Cumberland 1 ☑ Yes 2 ☐ No Directo Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 303 Greene Street USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Cashier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Keefer George 2 Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar Parsons / son 12803 Bunting Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery 01/25/2006 __ Cumberlard. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause or each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician EREBROVASCULAR ACCIDENT disease or condition resulting in death) 2 4RS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events siclan and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 □Ectopic pregnancy ò Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I the detached 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ has been signed 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? page certificate 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No after death. 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 | Homicide within 24 hours at To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) bastiano 3 2006 Turk 30. Name and address of person who completed cause of death (Item 23a) (Type Frint) nas 500 Memorial Avenue, Cumberland, MD Robustiano J. Barrera, M.D., 31. Date filed (Month, Pay, Year) JAN 2 4 2006 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					aryıan		rtificate c	f Health and of Death		Reg: No.	6 (147	68	
ı	Physici /Medic		Decedent's Name (First, Middle, Las Margaret Tilda Blank						2. Date of De Month	ary 28, 20		3. Tim 10:40	e of Death PM	
	Examir Funeral		4a Facility Neme (If not institution, give Devlin Manor Nursing 5. Social Security Number 6. Se	Home 7. Ag	je (In yrs. l	ast birthday)	If Under 1 Ye		nd	d Allegany 8. Date of Birth Month Pay Year) 9. Birthplace (State of Country)			te o <i>r Foreig</i> n	
	Director		Usual Residence of Decedent	□M 20X,F	47	Yrs.		, , , , , , , , , , , , , , , , , , , ,	22-May-	22-May-1958 Colorado				
	e Maryle Sa-f shov	ctor	Maryland Allegan		Cum	, Town <i>o</i> r Lo berland	cation					W .	e City Limits es 2 No	
	th with th	Funeral Director	10e. Street and Number 12525 Dia	mond Lane,	N.W.		10f. Zip Cod 21502			10g. Citizen of V U.S.A.	Whet Cou	ntry?		
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic evant, the Medical Examinat must be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:			Was Decedent of f Yes, specify C	of Hispanic Origin? (\$ uban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)	14. Rac Blac Specif	ce - Americ ck, White,	etc.	,	
Maryland 21215-0020	d within 72 hogiene. giene. er than "natui , the Medical	To Be Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 0	College (1-4or 5	5+)	16a. Deced (Give life. I		cupation ne during most of wo ired)	rking	homema		dustry		
yland	ould be file Mental Hy srkad othe	To Be	17. Father's Name (First, Middle, Last) Ora Joe Darby					18. Mother's Na	me (First, Middle, secamp	, Maiden Suman	ne)			
	and 2 sho raith and 1.27 is me ar traum		19a. Informant's Name/Relationship (T) Michael Darby	brother		10023	Deist Lane	FIC	ural Route Numb estburg	er, City or Town, Maryl :		Code) 215	532	
altimore,	Pages 1 and of He ut: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specify)			ace of Dispo emetery, cren dman Co	sition (Name of natory or other p emetery	olace)	Date 2006	20c. Location - Hyndman		wn, State		
Balti	permit. Departmine once. Proports any Inju		21. Signature of Funeral Service Licens	Dury	/			dress of Facility eral Home, 57	Frost Ave.,	Frostburg,	MD 2	1532		
) }	Physician /wedicar Examiner		23a Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Ceuse (Final disease or condition resulting in death)	ications that caused ne cause on each lin a.	hole	Do not ente	nel	dying, such as cardia	c or respiratory a	rrest,		Approxir Interval Onset ar	mate Between nd Death	
ox 68760,	= 0,40	In/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		as a consequal as a consequ								
P.O. Box	es that the death certific igned by the attending p be detached for use as	Physiclan/N	Part II. Other significant conditions cor	ntributing to death be	ut not resu	Iting in the ur	nderlying cause	given in Part I.		tobacco use col				
Vital Records, F	requir been s should	Completed by P							24a. Was	an autopsy rmed?	24b. We		sy findings or to	
tal K		Be Com	25. Was case referred to medical					26 Place of De	ath (Check only o	ree 2 M	10	Yes 2	?□ No	
<u> </u>	Physicien: r this certific ral director,	TO B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatie	nt 2□E	R/Outpatien	t 3□ DOA	Other: 4 Nursing I			er (Specif	1)		
Division of	ng fter	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	Year)	28b. Time of Inj <i>u</i> ry	28c. In	ijury at Vork? □ Yes 2 □ No		now injury occuri				
DIVIS	To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At hor . (Specify)	me, farm, stre	eet, factory, offic	ce	28f. Location (Street and Number or Rural Route Number, City or Town, State)				lumber,	
	na Hospit n 24 hour ne Funara	edical	29a Certifier Certifying Physical Certifying Physical Examination 2 Medical Examination		examination			time, data and plans y opinion, death occu					e(s)	
	withi To th		29b. Signature and title of certifier	lleno ha)			ense number	l l	29d. Date signer		-	7	
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	nh			LL Netin		Huy	420.	Lie 7	1 2/5	-0 i				
	Sta	e	31. Date filed (Month, Bay Year) AN 3 1 2006	2. Registra	s signati	Aca.	Nº .							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** February 5, 2006 10:40 PM Genevieve Margaret Bittinger /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dennett Road Manor Nursing Home Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 TKF Months Days Hours Director 219-56-9216 78 24,1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28e-f show other traumatic event, the Madical Examiner must be notified at 1 ☐Yes 2X No Director Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 1014 Hutton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 8th Custodian Department of Health and Mantal Health in Important: If Item 27 Is meany injury or others. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse James Bittinger Edith Mae Friend 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1014 Hutton Road, Oakland, Md. 21550 Zendil Bittinger/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2/9/06 Bittinger Family Cem. Swanton, MD 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland. Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death transitional cell CA if The bladder Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknow signed by t d be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tenuan, coronary arter 1 Yes 2 No 3 Probably 4 Unknown e fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate Yes 2 Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ZXNo Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 Tyes 2 No 2 Accident investigation Director: 6 Could not be determined 3 🗍 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier ween no garrett highway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 13079 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene per physician for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 7 2006° **Physician** February February Dorothy Jean Blackburn 3:40 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Westernport 105 Kelly Ave. Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 15 9. Birthplace (State or Foreign **Funeral** 79 Months Days Hours Min 1 M 250F 213-24-6627 Feb. Director 1926 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 28a-f ahow 10d. Inside City Limits ust be rutified at MD. Allegany Director Westernport 1XXYes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a or 105 Kelly Ave. 21562 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner: hours after ☐Yes 2 No Yes, Give Never Married 2☐ Married P. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural', Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Medical Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 Is marked other Be Howard Blackburn Theresa L. Gillespie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stable partment of Health ar important; if item 27 Is any injury or other trauonce. Peggy Harrison/ niece 105 Kelly Ave, Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 02/10/ 1 2 ☐ Cremation 3 ☐ Removal from State St. Peters Cemetery Westernport, Maryland 4 Donation 5 Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Wonic 54tans /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 honths?

1 Yes 2 Ho 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy ö Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. TO Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 22 No 1 ☐ Yes of Vital EXX No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To tha 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bisho Walsh Rd Cumberland MD2156 Hennawi 925 Ge0192 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				eartment of Health and Mental Hygertificate of Death	giene) 06 04771						
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death						
	Physici /Medi		Robert Allan Baile	ey Februa:	ry 1,2006 1355 M						
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		h 9. Birthplace (State or Foreign						
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	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ogation	10d. Inside City Limits						
	sho	5			1 ☐ Yes 2 ☐ No						
	1he A	Director	Md. Queen Annes Centre		A						
	with	5	2554 Churchhill rd		10g. Citizen of What Country?						
	s 23	eral		21617 Was Decedent of Hispanic Origin? (Specify Ves or No.	USA 14. Race - American Indian,						
′0	riten Inner	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.						
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21215-0036	within 72 hours after death with the Maryland ane. than "natural, or itams 23a or 28e-f show ta Madical Examinar mast be retified at	Completed		edent's Usual Occupation	16b. Kind of Business/Industry						
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ore	it of H if itel or oth		1 Durial 2 Cremation 3 Hemoval from State	ematory or other place)	20c. Location - City or Town, State						
Ë	t. Partmen	Н	`4 Donation 5 Dother (Specify) Md. Vet		Hurlock, Md.						
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			23a. Party. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respiratory are	rest, Approximate Interval Between						
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of	ਬੂ ≑ ਫ਼		27. Manner of Death 28a, Date of Injury 28b. Time of	Int 3 DOA 4 Nursing Home 5 Hesio	ence 6 ⊡Other (Specify) ow injury occurred						
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D	at or Attending P after death. I Director: After t d in by the funera	Certification:	4 Homicide building, etc. (Specify)	City or Town	n, State)						
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. ,	To To t	Σ	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)						
(1)	jeates		Hent Hos D	D17036 - mal	212/06						
(21.		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print) / 1 0/ 1 a	2/2/06 MA 21620						
			Susan K. Ross mp. 514 Woshi	ng ton Hoe. Chostnoon	MA 21620						
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:40 a ™ 2006 Feb. Sarah Christiana Bailey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SunBridge Care & Rehabilitation Elkton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/15/1923 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 82 221-16-2091 DE Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Itame 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes X☐ No **Funeral Director** MD Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 Deer Run 21915 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) le marked other than College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper permit. Pages 1 and 2 should be filled w Depertment of Health and Mental Hygier Important: if Item 27 ie marked other tt any injury or other traumatic event, titla 2002. 12 Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Nabb Sarah Savin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward Bailey/Son 40 Deer Run Chesapeake City, MD 21915 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cem. 2/7/2006 Earleville MD 4 ☐ Donation 5 ☐ Other (Specify) Fellows, Helfenbein & Newnam Funeral Home 226 E Main St Cecilton, MD 21913 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FUKOMIA /Medical Due to (or as a consequence of): Examiner Forlure 107 HRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-translt To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2√2 No 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an No De certificate 2 No 1 Tyes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natura! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title ertifier 29c. License number 29d. Date signed (Month, Day, Year) 03 FEB Ub erson who completed cause of death (Item 23a) (Type, Print) 30. Name and addre A720 NEW CASTE DE 817 CHURCHMAUS ARLEN C72 \sim 31. Date filed (Month, Day, Year) 32. Regidar's Signature State FEB 0 3 2006 Registrar DHMH 17 Rev 1/2001

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	Physici /Medio Examir	cal	Decedent's Name (First, Middle, L	Brown	_	4b. City, Town, or	Location of I	2. Date of Dea Month	Day Year O C 4c. County of Dea	3. Time of Death 3. 30 pm
	Funeral Director			1 Rd • Sex 1 M 2 12 T 7. Age (In yrs. It		Elktor If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birth Min. (Month, Day Januar)		thplace (State or Foreign ountry)
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36	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show officel Examinet must be notified at	by Funeral Di	222 Whiteha 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	11 Rd. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes, Give Year or Dates:		21	Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	U • S • A • 14. Race - Am Black, Whi	erican Indian,
21215-0036	be filed within 72 hourtal Hygiene. Id othar than "natural avant, tre Modical Er	Completed b	15. Decedent's t (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done a DO NOT use retired, OMEMAKET	furing most o		16b. Kind of Business Househo	s/Industry
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	ges 1 and 2 t of Health If item 27 or other tr		James T. Brown 20a. Method of Disposition 1 Burial 2 Deremation 3	□Removal from State	ace of Dispo metery, cre	sition (Name of matory or other place	Feb	7	e, Bear, 20c. Location - City of West Che	Town, State
Baltimore,	permit. Pag Department Important: any injury once.		21. Shalure	ensee	A:	rris Inc 2.Name and Addres ndrew G.	s of Facility Gee	Funeral	Home	
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.O. Box 68	at the death certifice by the attending phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[⊒Ectopic pregnancy □ Other (specify)			23d. Date of de Month	l Nivery Day Year
Records, P	ie law requires tha has been signed ge 2 should be de	Completed by Pt	Part II. Other significant conditions	contributing to death but not resu	lting in the u	nderlying cause give	en in Part I.	1 ☐ Y 24a. Was a autope perfor	an 24b. Were a	utopsy findings available completion of cause of
ion of Vital	ing Phyelcian: After this certification of the contraction of the con	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manny of Death 1 datural 5 Pending investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injury Work	or: 4 🗆 Nurs	f Death (Check only or ing Home 5 ☐ Resid 28d. Describe h	18)	Daughte
Division	To the Hospital or Attanding within 24 hours after death. To tha Funeral Director: Afte completely filled in by the fune	ai Certification:	3 Suicide 6 Could not determine)		e, Jats and	City or Tow	·	
)	5 W T S	Medical	(Check only 2 Medical Exicate) 29b. Signature and title of certifier	aminer: On the basis of examination and manner stated.	on and/or in	29c. License	ninion, death	occurred at the time, d	late and place, and du	e to the cause(s)
•	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 8 2006	32. Registrar's Signat	111 W.	est High	54.5	Duite 300	- Elkfon 1	102192/

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Bingham Charles 14:47 PM 01 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical ninsula NICOMICO 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 ☐ F Dec 16, 1953 ΜĎ 220-52-0629 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylei Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show with injury or other traumatic event, the Madical Examiner must be notified an once. 1 X Yes 2 No Completed by Funeral Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Second St. 21801 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Fenwick Inn 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Lee Thomas ပ္ Ethel M. Bingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel M. Bingham/mother 120 Second St., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Acres Mem Park 2/7/2006 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home alana Watsa 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fournier's **Physician** /Medical Due to (or as a consequence of): Examiner Type 2 Mellitus betes Dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, After this certificate hes been signed by the attending physicien funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Renal Insufficience 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? harles N. Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. nerel Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062130 MD 2006 ess of person who completed cause of death (Item 23a) (Type, Print) Healthwin Mi 21804 Salisbury Dr. M.D. 1104 Anoia Junes 31. Date filed (Month, Day, Year) 32. registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0629

Bingham

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		•	For Stata Registrar	State Of Wil	ai ytai i	•	rtificate				Reg. No.	06	04775)
,			Negistrar Necedent's Name (First, Middle, La	ist)						2. Date of Dea	ath		3. Time of Death	
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	Examine	_	4a. Facility Name (If not institution, given	ve street and number)			4b. City,	Town, or Lo	ocation of Death		4c. Coun	ty of Death		
	较		SALISBURY REHAB						, MD. 21			OMICO		
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	Director		19-34-2700 Usual Residence of Decedent		00					July 23,	1937	Alab	allia	_
ryland	how		10a. State 10b. County		1	y, Town or L	ocation						10d. Inside City Limits	
1215-0036 within 72 hours efter death with the Maryland	Ba-1 e	Director	Maryland Wicomic	0	Ŀ	Eden							1 ☐ Yes 2 🕱 No	0
with th	De no	Dire	10e. Street and Number				10f. Zip		0		10g. Citizen of		ntry?	
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الله الله	riten	Fun	1 Never Married 2 X Married	Amed Forces?					anic Origin? (Sp Mexican, Puerto	Rican, etc.)		ack, White,		
215-0036	Exa.	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	ZIALINO	Specify:		Spec	Blac	k	
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d 2	Hygi other	BeC	17. Father's Name (First, Middle, Las	t)		1			8. Mother's Nam					
Maryland	Aenta rked tlc ev	ToB	Jim		Pe	erry			Williem	ae		S	mith	
Haryla 2 should	and h	•	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ing Address	(Street and	d Number or Rur	al Route Numbe	ar, City or Town	n, State, Zij	p Code)	
	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Iteme 23a or 28a-f ehow any in ury or other traumatic event, the Medical Examiner must be notified at once.		Eugene Beaty, Sr./l	nusband	20h E	2517 Place of Disp	6 Sta	nford	Road -	Eden, M	laryland			-
~ 5 °	or oth		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 [0	cemetery, cre	imatory or o	ther place)		/2006		-		
J じない altimore,	Department Important: I any in ury o once.	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Spr	inghill							isbury, MD	
Balt Permit	Depa Impo any ir		De Most	B. 12	Plan				MORIAL				21801	
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c 68 artifica	ing ph e as th	Physician/Medic	IF FEMALE:								1	- 1		
BO)	or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	al death 3	□Ectopic pr					ate of deliv Month	very Day Year	
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Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate	been signed by the attending phy. should be detached for use as the	y Ph	Part II. Other significant conditions	contributing to death b	ut not res	sulting in the t	underlying c	ause given	in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?	
rds	on sign	ed by					_			10,	res 2 40	⊂ 3 ☐ Pro	bably 4 🗆 Unknow	/n
DCO aw re	2 sho	Completed								24a. Was		. Were aut	opsy findings available	le f
<u>a</u>	ate ha	Com								perfo	rmed?	death? 1 🗆 Yes		
/ita	ertific ector.	Be	25. Was case referred to medical examiner?	Hazaltalı.				1	26. Place of Dea					
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io i	al Direct	Cert	Tomode	building, et	ic. (Specif	·y)				0.1, 0.7 10.				
] the Hospital	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		Physician: To the best eminer: On the basis o and manner st	of examina									
To the	within To the	Me	29b. Signature and title of certifier	1 1			290	c. License r	number	0	29d. Date sign	ned (Month	, Day, Year)	
	UB.			18hows				0)	2739	1	7/2/	06		
	TO .		30. Name and address of person who							7.004	/ /			
		•	WILLIAM ROBINS, 31. Date filed (Month, Day, Year)	M.D. 200 C			SALI	SBURY	, MD. 2	21804				
	Sta Registr		FEB 0 3	407	Marie Salar		brett	P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No.

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>		lental Hygief (Reg. l		04776
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	Day Year	3. Time of Death
н	Physici /Medio		Elizabeth	Ellen	Bittinger			Februara	Year	6 15:55PM
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death	1	4c. County of Dea	ith
			Memorial	HOSDI	tal	(UM	perlor	19	Alle	gany
	Funeral			1 N 2 N E	e (In yrs. last birthday)	Months Days		8. Date of Birth Month, Pay, Yes Jul 24, 19	9. Bit	thplace (State or Foreign Office) MD
	Director		217-34-3978 Usual Residence of Decedent	7	77 Yrs.			Jul 24, 19	28	טוא
	and w		10a. State 10b. County		10c. City, Town or Lo	ocation		- 18		10d. Inside City Limits
	Mary!	ō	MD Allega	ny	Cumb	perland				1X Yes 2 No
	the 1289	rec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	3a or		220 Somerville A	venue Apt 5	17		21502		USA	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Exeminer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
9	after or Ite	Ē	1 Never Married 2 Marned	1 Tes 2	No	1 ☐ Yes 2 No		nican, etc.)	Black, Whi	
8	ours	d by	3 □ Widowed 🗡 □ Divorced	Year or Dates:		10 165 20 140	эрөспу.		Specify: wh	ite
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and	od ol	Be	Albert Miller	• • • • • • • • • • • • • • • • • • • •				Miller	on ounamo,	
2	2 should be and Mental is marked of reumatic eve	Ţ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	na Address (Stree	t and Number or Rura		v or Town, State.	Zip Code)
ĭ	0 0 0 0		Judy Stewart	daug		Clemen	t Street	Cumberl	and M	D 21502
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		ate 20c.	Location - City or	Town, State
9	Pages nent of I nnt: if it		1		Sunset Men	natory or other plans norial Park	2	2/14/2006 C	umberlan	d MD
Baltimore, Maryland 21215-0036	그 문란를 .		21. Signature of Funeral Service Lic		22	2. Name and Addr	ass of Facility III Funeral Ho	ma PA		
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			IF FEMALE:	23c. If yes, outcome	of pregnancy					
Box	etten for u	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnant Other (specify)	су		23d. Date of de Month	Day Year
<u>о</u> .	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time of death 3	J Other (specify)				
٦	The law requires that the death certif sie has been signed by the ettending page 2 should be detached for use a	P.	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause g	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
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Re	has ge 2	d l						autopsy performed	prior to	completion of cause of
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⋚	Physician: The lav this certificete has ral director, page 2	00	examiner?	Hospital:	ent 2 ER/Outpatier	it 3 DOA O	26. Place of Death		c Dother (Co	
ō	Phy or this aral d	J. To	27. Manner of Death	28a. Date of Inju (Month, Da		1 3C DOX 1	4 🗆 Null Sing Flor	ne 5 Residence 28d. Describe how in		icity)
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Division of Vital Records,	Atter r dea ector by the	HICE	3 ☐ Suicide 6 ☐ Could not	289. Place of In	ury - At home, farm, str	eet, factory, office		28f. Location (Street	and Number or Ri	ural Route Number,
ā	s after s after al Dire	Certification:	4 Homicide determine	building, at	(Spacity)			City or Town, Sta	110)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying F	hysician: To the best	of my knowledge, deat	n occurred at the t	ime, date and place, a	and due to the cause	(s) and manner as	s stated.
	the Ho in 24 ihe Fu	edical	one)	iminer: On the basis of and manner sta	ted.	vestigation, in my	opinion, death occurre	ou at the time, date a	and place, and due	o to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	/		29c. Licen	se number		Date signed (Mont	
•			P Uch	V		D	36766)-	elmy 1	4,2006
	1		30. Name and address of person who					1	0	
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State Registrar

FEB 1 7 2006

Box 68760.

P.0.

Records,

Division of Vital

State Registrar

FEB 0 6 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ROINTAN FARAHIFAR MO

			1 - For State Registrar	State of Maryla	nd / Depa		Health and	Mental Hy	giene	6 04778
	.4	٠,	Registrar 1. Decedent's Name (First, Middle, L	asti	Cei	uncate of	Dealii	2. Date of De	neg. 140,	
-	Physic		Elaine L. (Month	Day	Year
	/Medi Exami		4a. Facility Name (If not institution, g			4b City Town	or Location of Dea	Januar	y 23 2 4c. County	006 1752 P M
7	LAdiiii	ilei	Prince George				Cheverly			ce George's
	 Funeral 		5. Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Yea	r If Under 24 Hr	s. 8. Date of Birt	h	Birthplace (State or Foreign Country)
	Director		579-84-4217 Usual Residence of Decedent	1□M 2□F	45 Yrs.	Months Days	Hours Mir	Aug. 6	1960	Wash., DC
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	72 hours effer death with the Maryland "naturel", or freme 23a or 28a-f ehow odical Exartic or must be notified at	Director	Maryland Prince	George's			pitol He			1 XYes 2 No
	3a or	io =	6304 Foote St.			10f. Zip Code	20743		10g. Citizen of W	what Country? ed States
	death	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. \	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No-	14. Race	- American Indian
9	efter or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?				rto Rican, etc.)	Blac	k, White, etc. Af ri can
93	rel', c	1 by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		∏Yes 2. No	Specify:		Specify.	American
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, Maryland 21215-0036	nd 2 alth a 27 is r trau		Ruby A. Wanam	naker/Sister	6304	+ Foote	St., Cap			20743
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Place of Dispos cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location - (City or Town, State
Ë	permit. Page Depertment of Important: If eny injury or once.		4 Donation 5 Other (Special	fy)	Lee's (Cremator		7/2006		nton, MD
39	Depermit Depermit Import In port In port		21. Signature of Funeral Service Lice	insee A A -	22	Name and Addre		Stewart F		
			John .	Mewary 1			enning Ro			OC 20019
345	Physician /Medical		23a. Part1. Enter the disease, or con shock, or leart failure. List only Immediate Cauge (Final disease or condition resulting in death)	a. HIV	DIAL	2				Approximate Interval Between Onset and Death
* 3	Examiner		Sequentially list conditions	interview	mence of):	ar um	al July o	rachie	wid h	emorthage
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	40000 017.	Sion				
Ć.	execu in and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consec		/-				
8760,	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	icai	(d						
9 ×	ertifica ling pt e as ti	Med	IF FEMALE:							
Вох	es that the death certific igned by the ettending p be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta	aldeath 3 🗌	Ectopic pregnanc	у		23d. Date Mont	of delivery th Day Year
P. 0.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of o	teath 5∐	Other (specify) _				Jay Tour
مز	that ed by deta	F.	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause gr	ven in Part I.	23e. Did to	bacco use contrit	bute to the cause of death?
Records,	quires n sign	0								3 Probably 4 Unknown
၀	s been si	Completed						24a. Was a	n 24b. W	ere autopsy findings available
æ	The lay te has age 2	E O						autops	ned? de	or to completion of cause of eath?
ā	an: trifica for, p	Be C	25. Was case referred to medical				26 Place of De-	1 ☐ Yes :		Yes 2 No
>	Physician: The la	ToB	examiner? 1 ☐ Yes 2 ☐▼No	Hospital:	ER/Outpatient	3□ DOA Ott		lome 5 ☐ Reside		(Specific)
Ö	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur	y at	28d. Describe ho		
Ö	uttendin death. ctor: Afr	atio	1 Natural 5 Pending 2 Accident Investigation	n	Injury	M 1 🗆	Yes 2 □ No			
Division of Vital	ire ire	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled is	Medicai (29a. Certifier (Check only one) 1 X Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death ition and/or inve	occurred at the tirestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	ause(s) and mani ate and place, an	ner as stated. Indicate to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	10 cun		29c. Licens			9d. Date signed ((Month, Day, Year)
)			ym. su			Dox	5998	1	1/30/	06
	(2)		30. Name and address of person who				77.0 (1	ow1 300	20705	
.57	Sta	e	Mukemil Abdo 31. Date filed (Month, Day, Year)				lve, Chev	erry, MD	20785	
1982	Registra		ECD 0 6 200	. Registrar's Signa	Mary	81				

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment rtificate	t of H	ealth a Death	ind Me		giene leg. No.	06	04779
200	Physic	an	Decedent's Name (First, Middle, La							2	. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi		KENNETH	M				IAPM/			ANUARY		2006	6:20 A M
	Examir	ner	4a. Facility Name (If not institution, giv PRINCE GEORGE HOSI		oer)				Location o	f Death			unty of Deat	
			5. Social Security Number 6.3		Ane (In vrs.	last birthday)	CHEV If Under		L If Under 2	24 Hrs. g	Date of Birtl		NCE GE	
	Funeral Director			M 2□F	63	Yrs.	Months	Days	Hours	Min.	Date of Birtle (Month, Day (NEMBE)			hplace (State or Foreign ountry) YLAND
			Usual Residence of Decedent							411	VILIDII			
	show	7	MD 10b. County PRINCE (EORGE		ty, Town or Lo VDOVER								10d. Inside City Limits Ty Yes 2 □ No
	1889-1	ecto			2711	VDO V LIK						0.00	-1340	21
	with t	급	10e. Street and Number 4005 70th AVE				10f. Zip					•	of What Co	ountry ?
	eath	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.1	207 Was Deced		spanic Orio	in? (Speci	fy Yes or No-	U.S.		rican Indian,
ı,	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f show dical Examirat must be notified at		1 Never Married 2 Married	Armed Forc	es?		f Yes, spec	ify Cuba	n, Mexican	, Puerto Ri	can, etc.)		Black, White	e, etc.
ğ	rel', o	b	3 N Widowed 4 □ Divorced	If Yes, Give Year or Date	9s:		1 ☐ Yes 2	X No	Specify:			Sp	ecify:BLA	CK
2-0	be filed within 72 hours ital Hygiene. Ind other than "naturel", event, the Madical Exe	Completed	15. Decedent's E (Specify only highest gro			16a. Deced (Give	kind of won	k done d	luring most	of working	,	16b. Kind	of Business/	Industry
2	within ene. then	пр	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT us					D		
N D	filed v I Hygie other t		17. Father's Name (First, Middle, Last)		SECUR	IIY G	UAKL		r's Name (First, Middle,	PRIV Maiden Su		
Maryland 21215-0036	Mental arked o	To Be	JAMES CHAPMAN						JULIA	,			,	
3	d 2 should be the and Menta the and Menta 7 is marked traumatic events.	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	r or Rural F	Route Numbe	r, City or To	own, State, 2	Zip Code)
	1 and 2 Health a tem 27 le		LORAINE CHAPMAN/D	AUGHTER		4005	70th .	AVE	LANDO	VER I	HILLS,	MD 20	784	
Baltimore,	of Healt		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			Place of Dispo	sition (Nam	ne of ther place	9)	Dat	0	20c. Locat	ion - City or	Town, State
Ĕ	Pages ment of ent: If It ury or o		4 □Donation 5 □ Other (Special		MD :	NATION							L, MD	
3alt	permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service Lice	1500	00						ENKINS			OME
	40 = 0		23a. Part1. Enter the disease, or comshock, or heart failure. List only	aho	W.						DOVER,		0785	Approximate
	death certificate be executed Water transition and death cuts as the burial transit General transition and the purial transition are the purial transition.	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. END S Due to (Jr	as a conseq	RENAL D	ISEAS	E						
O. Box 6	the che	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2∐Feta itattime ofd	Ideath 3	Ectopic pre					23d	. Date of deli Month	ivery Day Year
S, L	ge of the	by P	Part II. Other significant conditions	ontributing to deat	h but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	bacco use		the cause of death?
g	w requires been sign should be							-			1 🗆 Y	es 2 N	lo 3 Pr	obabły 4 X Unknown
ပ္ပို မ	as b	Completed									24a. Was a autops	v	prior to d	topsy findings available completion of cause of
I E	The Page	Con									perfor	med? 2∰ No	death? 1 ☐ Yes	2 No
<u> </u>	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho	-		Check only or			
0	Phye this al dir	은	1 ☐ Yes 2 📉 No 27. Manner of Death	1 Inp		ER/Outpatien			4 🗆 1901		5 Resident. Describe he			cify)
o	ding After fune	ton	1 Natural 5 Pending 2 Accident Investigation	(Month,	Day Year)	Injury	м	3c. Injury Work 1 □ Y	.?` ′es 2 □ N		2. 20301120 11	on injury or	201100	
DIVISION OF VITAL RECORDS,	or Attending after death. I Director: After d in by the fune	ertification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	Injury - At ho , etc. (Specif	ome, farm, stre	eet, factory,	office		28	Location (S. City or Town		umber or Ru	ral Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manner	s of examina	wiedge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, and h occurred	d due to the c at the time, d	ause(s) and ate and pla	d manner as ice, and due	stated. to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier				29c.	License	number		2	9d. Date si	gned (Monti	n. Day, Year)
			Shelete	21Cal		\preceq		DI	487	16		1-3	1-00	6
R	(4)		30. Name and address of person who	1A 35	03 KE	RRY.	Print)	Mr	San	nel	MU	20	17/2	
100	Sta Registr		31. Date filed (Month, Day, Year) FER 0 3 2006	32. Reg	istrar's Signa	itue .	U	,						

			For 1 = State Registrar	State of I	Marylan		artment rtificate				lental Hy	giene () ()	16	04780
		20	1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea			3. Time of Death
	Physici		4/.	K				C	in a i		Month	Day	Year	7:30 PM
	/Medi		4a. Facility Name (If not institution	a aive street and number	er)		4b. City.		Location	of Death	_	4c. County	of Death	7.30
1	Examir	ner					.0			0. 202		,,		
		XX	University of Ma	6/ Sex 7.	Cal Ce	last birthday)			If Under	24 Hrs.	8. Date of Birt	h	9 Rintho	lace (State or Foreign
6	Funeral		203-50-5591	1X□M 2□F	61	Yrs.	Months	Days	Hours	Min.	Feb. 16	1944	Cour	pan
Er.	Director		Usual Residence of Decedent	<u> </u>							160. 10	, 1311		pan
	and **		10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
	ith the Marylar or 28a-f show	ö	Maryland Mont	gomery	Si	lver S	nrina							1 ☐ Yes 2 No
	28a-	ect	Maryland Mont	.gomery	51	rver 5	10f. Zip	Code				10g. Citizen of V	What Cour	ntry?
	di di	급	9820 Colesvill	o Dood			209					USA	rviiai Coui	itt y :
	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Evanicatinative Dudilled at	by Funeral Director				2 142								
	e de	n n	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Deced If Yes, spec	lent of Hi rify Cuba	spanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	- 14. Had Blac	e - Americ ck, White,	
36	orl	y F	1 Never Married 2 Mar	If Yes, Give			1 ☐ Yes 2	No	Specify	:		Specify	Asia	n
21215-0036	ural.		3 Widowed 4 Divorced		s:	1								
5	72 h	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usua kind of wor	k done d	lurina mos	st of work	ing	16b. Kind of B	usiness/Ind	dustry
2	within ene. then.	ld I	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT us	e retirea	,			Educati	ion C	onsultant
	ygier ygier t, th	Ö		5+		Eau	cator							Olisui talit
pu	al H d off	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle,	Maiden Suman	10)	
<u> a</u>	Vent Went Went wrke	2	Injoo Choi						500	n Nai	n Chang			
Maryland	d 2 should be filed within hand Mental Hygiene. 7 le marked other then " traumatic event, the Med		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address	(Street a	ind Numb	er or Rur	al Route Numbe	er, City or Town,	State, Zip	Code)
	and 2 balth n 27 i		Sunny M. Choi/	Wife		9820	Cole	svil	le R	oad,	Silver	Spring,	MD	20901
<u>ව</u>	S 1 a		20a. Method of Disposition			lace of Dispo	osition (Nam	ne of	9)	Fobri	Date	20c. Location -	City or To	wn, State
2	Pages nent of int: If its		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		IIA I	lawn Me			1.		006	Rockvil	lle,	Maryland
Baltimore,	H E LO LE A		21. Signature of Funeral Service		2	2:	2. Name and	d Addres	s of Facili	itv.				
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23s or 28s-1 show eny highty or other traumatic event, the Mudical Everificat must be notified and once.		· Willi	J Byl	/	5	00 Un	iver	sity	Blv		ilver Sp	ring	, MD 20901
	×		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	r complications/that caus t only one cause on each	sed the deat n line.	h. Do not en	ter the mode	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		as a conseq									
	Examiner													
		Į.	Sequentially list conditions,		as a consequence	no hom	5							
	ed ns:t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<										
	and I-trar	хап	that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of):								
90	cien cien curia		-											
8760,	The law requires that the death certificate be executed wie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transitions.	Physician/Medical		d							· · ·			
9	ing p	Mec	IF FEMALE:	T										
Вох	death certifical attending phy of for use as th	an/l	23b. Was decedent pregnant	23c. If yes, outcor			Ectopic pre	egnancy					te of delive inth	ory Day Year
Э.	the att	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant		eath 5	Other (spe	ecify)				Mid	WILLI	Day 19a1
P.0	that the death ed by the atte detached for	h,	9 Unknown	3EJ OTIKTOW										
	res that signed to be det	by P	Part II. Other significant conditi	ons contributing to death	n but not res	ulting in the u	inderlying ca	ause give	n in Part	l.	23e. Did to	bacco use cont	inbute to th	ne cause of death?
ğ	quire n sig uid b	ğ									1 🗆 Y	es 2 No	3 🗌 Prob	ably 4 □Unknown
of Vital Records,	w requir been si should	Completed									24a. Was	an 24b.	Were auto	psy findings available
æ	hes hes	m du									autop	sy	prior to cor death?	mpletion of cause of
<u></u>													1 🗌 Yes	2 1 No
<u></u>	Physicien: The this certificate he ral director, page	Be	25. Was case referred to medical examiner?	Unantal d				Othe			h (Check only o			
5	this al div	٩	1 ☐ Yes 2 ☑ No	1 W Inpa		ER/Outpatier		^	4 🗆 141	ursing Ho	me 5 Resid			()
_	Jing F After funer	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of li (Month, i	Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe h	low injury occur	rea	
Division	Attending in death. ctor: After by the fune.	cat	E - 7.00.00.11	gation			М	1 🗆 1	/es 2 □	No				
Ξ̈́	r Att	ţ	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of	Injury - At ho etc. (Specify		reet, factory	, office			28f. Location (S City or Tox		er or Rura	I Route Number,
	rs af	Cer												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical	ng Physician: To the be Exeminer: On the basis	of examina	wiedge, deat tion and/or in	h occurred a	at the tim	e, date ar	nd place, ath occur	and due to the or	cause(s) and ma	anner as st	ated. the cause(s)
	thin 2 the 2 the 1	Med	one) 29b. Signature and title of certifie	and manner	stated.		29c	. License	number			29d. Date signe	d (Month,	Day, Year)
	E . ₹ E 8						D	10	1 2	4		1 /	,	
1	O		Melisa K	3cm MD			<u> </u>	1]	0)			3/3/0	36	
			30. Name and address of person									, ,		
			Melissa Bak	ar 10671	Grane	tura Pl	ace	Colu	nbig	MA	21044			
	Sta		31. Date filed (Month, Day, Year,	32. 26 gi	strar's Signa	ture	mente	7						
1	Registi	ar	LFR A	6 2006	Jans 1	es by	T.T.							

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

2. Date of Death

Month

-eb

Jan 292006

home

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

37 Registrar's Signature

-M.D.

M.D

1 - For State Registra

Jgorn

5. Social Security Number

Physician

/Medical

Examiner

Funeral

Decedent's Name (First, Middle, Last)

Chhay

University of Maryland Medical Centr

1⊠M 2□ F

6. Sex

4a. Facility Name (If not institution, give street and number)

3. Time of Death 600 AM 2006 4c. County of Death Birthplace (State or Foreign Country) Cambodia 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: Asian 16b. Kind of Business/Industry Cambodian Government 20c. Location - City or Town, State 02/11/2006 Silver Spring, Maryland imate erval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗆 Yes 28f. Location (Street and Number or Rural Route Number. City or Town, State) 502 Fireston Drive 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

after death.

To the Hospitel or At within 24 hours after of To the Funerel Direct

filled in by the

completely

Medical

State

Registra

Division

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

5 Pending investigation

6 Could not be

6012teder

0 6 2006

2300

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

29c. License number

P17634

225. Greene Street Battimore, MD 21201

Feb

2006

			1 - For State Registrar	State of Maryla		artment of I		Re	2006	04782	
5	Physici	ian	1. Decedent's Name (First, Middle, Last	•				Date of Death Month	Day Year	3. Time of Death	
1	/Medi		Raquel 4a. Facility Name (If not institution, give	Cohen		4h City Town	or Location of Deal	February	2, 2006 4c. County of Dea	1:30 am	_
	Examir	lei	2006 Flowering Tr			Silver			Montgom		
No.	- Funeral Director		581-50-6896	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Biri	thplace (State or Foreign	_
	he Maryland 28a-f show culfied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		City, Town or Lo	Spring				10d. Inside City Limits 1 ☐ Yes 2 No	_
	with t	Dir	10e. Street and Number 2006 Flowering T	ree Terrace		10f. Zip Code 20902	,	10	g. Citizen of What Co USA	ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show similary or other traumatic event, the Midical Examinary mat be mailled at ODGE.	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.	
21215-0036	within 72 ho ane. than "natur se M. dical.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire amstress	during most of wa	arking	6b. Kind of Business		
Maryland 2	uld be filed Mental Hygie rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Francisco Martin	ıez				me (First, Middle, Mi ina Orsini	aiden Sumame)		_
, Mary	and 2 showed the and N n 27 is maner trauma		19a. Informant's Name/Relationship (T) Jarrett C. Cohen/	Son	2006	Flowering			City or Town, State, 2 .lver Spri	Zip Code) ng, MD 2090:	2
Baltimore,	tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ga	te of He	sition (Name of natory or other plai aven Cemete	ery	ruary 6, 2006 Si		Town, State ng, Maryland	đ
Ba	Depar Impor sny ir		21. Signature of Funeral Service Licens	Sils.	50	0 Univers	sity Blvd		er Spring	, MD 20901	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dearne cause on each line. a. Gastric Can Due to (or as a conse	ccinoma	er the mode of dyir	ng, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death 2 Years	
8760,	cate be executed obysician and the burial-transit	lical Examiner	Sequentially list conditions, if any least the individual cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to for as a consuct. Due to (or as a consect.)							_
P.O. Box 68	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time ot 9 Unknown	al death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of dea	ivery Day Year	
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause giv	ren in Part I.		cco use contribute to	the cause of death?	
Division of Vital Records,	The ate h page	Completed						24a. Was an autopsy performs	prior to death?	topsy findings available completion of cause of 2 No	
\rightarrow	sicial certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatien	Oth		ath (Check only one)			
ion of	Attending Physician: Ir death. sctor: After this certifice by the funeral director.	ertification: To	27. Manner of Death P☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 14d13i11g1	28d. Describe how	ce 6 Other (Special injury occurred	city)	-
DIVIS	2 # # 0	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ify)			City or Town,			
	To the Hospital (within 24 hours at To the Funeral D completely filled in	fedical	one) Z Medicai Exami	sician: To the best of my kn mer. On the basis of examin and manner stated.	owledge, death auon andvor inv	estigation, in my o	pinion, death occu	urred at the time, date	and place, and due	to the cause(s)	
	2 2 2 2	W	29b. Signature and title of certifier			29c. Licens D622			d. Date signed (Monti ebruary 2		
			30. Name and address of person who co	.D. 9707 Me	edical	Center Di	rive, Roc	ckville, M	D 20850		
	Sta Registr		31. Date filed (Month, Day, Year)	3 Registrar's Sign	ature	Si)					

			1 - For State Registrer	State of	Marylan		artmen rtificat				lental Hy	/giene Reg. No.	000	5	047	83
	Physici	an	1. Decedent's Name (First, Middle Gertrude E. Col	•							2. Date of Do		Y	ear	3. Time of	Death
	/Medi										Februa Februa)6	9:18	ΑM
4	Examir	ner	4a. Facility Name (If not institution,	•	ber)				Location of	of Death			County of I			
			419 Russell Ave 5. Social Security Number		. Age (In yrs.	last hirthday)	If Under		burg If Under	24 Hrs.	9 Date of Bi		ontgo			
	Funeral Director		109-18-8418	1□ M 25kF	81		Months	Days	Hours	Min.	8. Date of Bi (Month, Di May 6	ay, Year) 192		Cour	olace (State or ntry) sylvani	
	D		Usual Residence of Decedent								1145 0	, 1,2			y i vaii i	.a
	Marylar a-f show	tor	Maryland Montg	omery	1	ty, Town or Lo Lthersb								1	l 0d. Inside Cit 1 ☐ Yes	-
	th the	irec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha	at Cour	ntry?	
	23a d	ral	419 Russell Ave	nue, #517			2	20877				Unit	ed St	ate	es	
920	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Exam in court to multiply any order.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠ No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)		14. Race - , Black, \ Specify:	White,		
5-0	72 ho	etec	15. Decedent' (Specify only highes	s Education grade completed)		16a. Dece	dent's Usua kind of wor	l Occupa	ition urina mosi	t of work	ina	16b. Kir	nd of Busin	ess/In	dustry	
121	vithin ne. han *	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of wor DO NOT us				9					
7	iled w Hygie ther ti		17. Father's Name (First, Middle, L	4 4		Но	memak	er	10 Motho	rio Alam	First, Middle		n Hom	ıe		
Maryland 21215-0036	d 2 should be filled within h and Mental Hygiene. 7 Is marked other than "raumatic event, the Mec	To Be	Wiles Edwards						Alic	e Pe	arson					
	and 2 shoalth and 27 is m		John D. Collins			19b. Mailir 150 N	ag Address . Moh	(Street a	nd Numbe Circ	or Rura cle,	Boca F	er, City or Raton	Town, Sta	te, <i>Zip</i> 334	Code) 87	
Baltimore,	Pages 1 and of He nt: If item	, A	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate 1	Place of Dispo emetery crer Metropo emator	317 fa	her place N) F	ebru 200	lary 4,		ation - Cit andri		own, State	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service t	MO06		22	. Name an	d Addres		y De	Vol Fur Drive,	eral	Home	,	, MD 2	0877
			23a Party Enter the disease, or o shock, or heart failure. List of										ilet 2D	urg	Approximate Interval Betw	
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		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U.	as a consequ	ve Dis	ease							1	2 year	S
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	с.												
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.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		h 2 ⊡Fetal Itat time of de	I death 3 □	Ectopic pre Other (spe					2	3d. Date of Month		,	ear
s, P	uires that n signed b	b	Part II. Other significant condition	s contributing to deat	th but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.			_			e cause of de	
OS	≥ .0 .0	iete									24a. Was	an	24b. Wer	e autor	psy findings av	vailable
of Vital Record	The ate h page	Completed									autor	osy ormed? 2 \(\overline{A}\) No		to cor h?	npletion of car 2□ No	
Ζ	Physician: this certitica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othe			Check onl					
	Phys)— J	27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of	-	Sc. Injury Work	4 🗀 1401	-	ne 5 🖰 Resi 28d. Describe I			Specify	')	
ion	Attending of death.	ation	1 Accident 5 ☐ Pending	(Month,	Day Year)	Injury	М		? es 2 □ N			, ,				
Division	after death. after death. I Director: A d in by the tu	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	eet, factory,	office		2	28f. Location (. City or Tou		Number o	r Rura	l Route Numb	er,
	e Hospital or Att 24 hours after de e Funeral Direct letely tilled in by t	edicai C	29a. Certifier (Check only one) 1 ☑ Certifying 2 ☐ Medical E	Physicien: To the be xaminer: On the basi and manner	s of examinat	wledge, death tion and/or inv	occurred a restigation,	t the time	e, date and nion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	and manne place, and	r as st due to	ated. the cause(s)	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (M	lonth, L	Day, Year)	
	Q		Sel. 12 1	Wiland	28	1	I	192	294		1	Febru	ary 2	2, 2	2006	
	U		30. Name and address of person w	ho completed cause	of death (Item	23a) (Type, I	Print)									
			John R. Melnick	M.D., 91	1 Russ	ell Av	enue,	Gai	thers	burg	g,_Marv	land	2087	9		
	Sta	_	31. Date filed (Month, Day, Year)													
	Registr	ar	FEB 06	ZUUD	Kas Ki	- John										

		1 - Stata Registrar	State of M		Certificat	te of D	Death		Reg. No.		0 , 10 .
		Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Yeer	3. Time of Death
hysici /Medio		Marie	Louis	e Cre	eighton			Februar	y 6 , 20	006	7:00 A
xamir		4a. Fecility Name (If not institution,	•	er)	4b. City,	, Town, or	Location of De	eath		ounty of Deat	
		12205 Riverview Ro				Washir	0			rince Ge	
neral ector		5. Social Security Number 579-62-6638	6. Sex 7 1 ☐ M 2XXF	Age (In yrs. last birtl 94 Y	Months	Days	Hours M	in. May Morg, D	rth 1 911 <i>er)</i>	Co	hplace (State or Forei untry) nsylvania
18		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limit
H Di	ក	Maryland Prince (George's	Ft. Was							1 ☐ Yes 🛣 N
all of	Director	10e. Street and Number				p Code			10a Citizo	in of What Co	
110	Ξ	12205 Riverview Ro	ned.		101. 24	20744	<u>'</u>		US		unity :
	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Was Dece	dent of His	spanic Origin?	(Specify Yes or N		. Race - Ame	
	by Fur	1 ☐ Never Married 2 ☐ Marrier 3 ☑ Widowed 4 ☐ Divorced	Armed Force Id 1 Yes 2[If Yes, Give Year or Date:	™ No	If Yes, spe 1 ☐ Yes		Specify:	erto Rican, etc.)	S	Black, White pec <i>ity:</i> Whi	•
4	ed	15. Decedent's	Education	16a. I	Decedent's Usu	al Occupa	tion		16b. Kind	of Business/	Industry
Wed	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c		'Give kind of wo life. DO NOT u	ork done d use retired)	uring most of v	vorking	Pol:	gion	,
6	mo;	Libinorially/Secondary (0-12)	2		scopal_	Bisho	op's Wi	fe	Well	gion	
vent	Bec	17. Father's Name (First, Middle, La	ast)	_			18. Mother's N	lame (First, Middle		umame)	
atic 4	To	William	Wendel				Ethel	Shallcr		Rowlan	
mne.		19a. Informant's Name/Relationship						Rural Route Numb			
her ti		William W. Creigl	hton - Son		and the second second second			Ft. Wash:			
any injury or other treumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		cemetery	Disposition (Nai , crematory or o	other place	1	Date		ition - City or	
jury		*4 □Donation 5 □Other (Spe		Kalas	Cremato			. 7,2006	Edgew	ater,	MD
any ir		21. Signature of Funeral Service Li	censee		22. Name ar	nd Addres:	s of Facility (George P. K Oxon Hill,	alas Fu Marylan	meral Ho	ome P.A. +5
Medical Medical kaminer with private programmer was the private of		23a. Part1. Enter the disease, or conshock, or heart failure. List or timmediate or condition.	omplications that caus nly one caus, on each	sed the death. Do not line.	1						Approximate Interval Between Onset and Death
dical iner	ical Examiner	shock, or heart failure. List or	a. Due to (or:	as a consequence of	ot enter the moo						Approximate Interval Between
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			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment ertificate			and M	lental Hy	gieni Reg. No			04785
			1. Decedent's Name (First, Middle, La	ist)						2. Date of De	ath			3. Time of Death
	Physici		OLIVIA MAE CART	FR						Month FEBRUA	Da A D V	•	9ar 006	
-	/Medi Examir		4a. Facility Name (If not institution, gir		ner)	4b. City, To	own, or L	Location o	of Death	FEDRUZ		County of		11:25A ^M
	=,		HOLY CROSS HOSP			ST	LVFR	SPR	TNG			MONTG	MEI	ov
	Funeral		Social Security Number 6.	Sex 7.	Age (In yrs. last birthda)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bir	th			lace (State or Foreign
	Director		201 20 4097	1□ M XX F	81 Yrs.	Months	Days	Hours	Min.	(Month, Da	1 , Year,			NSYLVANIA
	ը _		Usual Residence of Decedent								-) 1	7211		IDIE VIII III
	ehow	_	10a. State 10b. County		10c. City, Town or I	ocation							1	0d. Inside City Limits
	9 Mg	5	MD MONTGO	MERY	SILVER S	PRING								XX Yes 2 □ No
	or 24	Sire	10e. Street and Number			10f. Zip C	Code				10g. Ci	tizen of Wha	t Cour	itry?
	23.	Funeral Director	901 ARCOLA AVEN	UE		20	906				UN	ITED S	STAT	TES
	tems	rue	11. Marital Status	12. Was Decede Armed Force	es?	Was Decede If Yes, specif	nt of Hisp y Cuban,	panic Orig	gin? (Spe	ecity Yes or No Rican, etc.))-	14. Race - Black,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX Divorced	1 ☐ Yes 2 If Yes, Give	(XNo	1 ☐ Yes 💥	277	Specify:				Specify:		
Ô	hour ture!	D D		Year or Date										
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-1 ehow the Medical Exemirar must be notilised at	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual e <i>kind of work</i> DO NOT use	done du	ion i <i>ring m</i> ost	t of worki	ng	16b. k	(ind of Busin	ess/Ind	dustry
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d 2	2 should be filed withir and Mental Hygiane. Is marked other then eumatic event, the Ms		17. Father's Name (First, Middle, Las.	')	OF	FICE M			r's Name	(First, Middle		EDUCA Sumame)	TITC	JN
Maryland	ould be Mental I arked o	To Be	CALVIN BLACK, S	R						CKSON	,			
<u></u>	should nd Men marke imaric	-	19a. Informant's Name/Relationship		19b. Mai	ing Address (Street an			I Route Numb	er City	or Town Sta	te Zin	Code)
≥	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiane. If Item 27 is marked other then "naturel", or Items 23e or 28e-1 ehov or other treumatic event, the Medical Exeminar must be notilitied at		CHARLENE A. WAR			RAVEN				EW CARE				,
ē,	Health tem 27 other tr		20a. Method of Disposition	7 211001	20b. Place of Disp	osition (Name	of			ate		ocation - Cit		
JI O	Pages nent of f ant: If Its ury or o		XX Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ate	matory or oth		1	2/11	12006	DD	ENTERIO	, D	MD
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			23a. Part Enter the disease, or con	plications that cau	sed the death. Do not e	ter the mode	of dying,	such as	cardiac o	r respiratory a	rrest,	D, MD	207	Approximate
	Physician		shod, or heart failure. List only Immediate Cause (Final											Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a. SEPSIS	as a consequence of):									
	Examiner			, PNEUMO	NTA									
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Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11					of Death	(Check only o	one)			
of	Physician: this certific ral director,	ဥ	1 ☐ Yes XX No	Hospital: XX Inp				4 🗆 1401		ne 5 🗆 Resi			Specify	')
	After Vune	0	27. Manner of Death XXX Natural 5 ☐ Pending		njury 28b. Time Day Year) Injury		. Injury a Work?			28d. Describe I	how inju	ry occurred		
Si	Attending in death.	cat	2 Accident investigation 3 Suicide 6 Could not be		falses Abbass (М		es 2 🗆 N			_			
Division	2 2 2 2	Certification:	4 ☐ Homicide determined	28e. Place of	Injury - At home, farm, s , etc. (Specify)	reet, factory, o	office		1	28f. Location (City or To	Street ai wn, State	nd Number (e)	r Rura	Route Number,
	splta ours seral		29a. Certifier XX Certifying P	Veician: To the b	est of my knowledge, dea	th occurred at	the ti-	dete	d plane	and direkting) d ::'		
	24 h	Medical	(Check only 2 Medical Exe	miner: On the basi and manner	s of examination and/or i	in occurred at ivestigation, in	ne time my opir	nion, deat	n place, a	and due to the ed at the time,	date an	d place, and	or as st due to	ated. the cause(s)
	within 24 h	Me	29b Signature and title of certifier	25 /// (1/1/10)		29c. 1	License r	number			29d. Da	ite signed (A	fonth, i	Day, Year)
	1		tuhu	260	DOR) ,	D344	72						
	(14)		30. Name and address of person who	completed cause	of death (Item Da) (7)		J44	14			LED	RUARY	05,	2006
	(pc		LYNNE DIGGS, M.		O CONNETICU		#20	6 KI	ENST	NGTON,	MD '	20895		
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	istrar's Signature	T 17.V LI 6	1120	0 1(1	TINT	HOTON,	, CH2	20093		
			CCD 0 7 7006 Z	Muse of the										

State of Maryland / Department of Health and Mental Hygiene 0 0 11:786 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Shu-Hsien Chou February 3, 2006 4:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye **Funeral** Months 1 M 20 F 071 44 1946 63 July 6, Director 1942 Taiwan Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f ahow 10d, Inside City Limits other traumatic ayant, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 10702 Cleo's Court 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes **2** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Asian þ Specify 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Meteorologist NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be file partment of Health and Mental Heportent: If item 27 is marked off y injury or other traumatic eventy Be Yao-Chung Chang Mei Chen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ming-Dah Chou/Husbnad 10702 Cleo's Court Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Importent: If any injury or once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 2/4/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pk. Ellicott City, MD Ludel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endometrial Carcinoma months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying trace (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE esn esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No į Month Day Year 5 Other (specify) 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospice 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni bellii 4 - Homicide within 24 hours a To the Funeral D Hospite Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 February 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print))ad 6601 N. Charles St. Aaron Charles, MD Baltimore, MD 21204 32. Halistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	m∦		h,bg,2/16/0)6 Ce	ertificate of	Death		Reg. No.	2006	0478
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ledic		4a. Facility Name (If not institution,	LVILLE COTT		4b. City. Town.	or Location of Death	+EBRU		3 , 2000 County of Deat	
amin	er	0 1 1	al Medica	center		salisbury			Wicom	
eral		5. Social Security Number 6	6. Sex 7. A	ge (In yrs. last birthda 75 Yrs.	y) If Under 1 Year Months Days	If Under 2 Hrs. Hours Min.	8. Date of Bi (Month, D) 04/26	irth	9. Birti Co	hplace (State or Foreig
ctor		002-20-2379 Usual Residence of Decedent		75 Yrs.			04/26/	730	New	Hampshire
3		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
I United for notified at	cto	Maryland Some	rset	Princ	ess Anne					1 78s 2 N
	Funeral Director	10e. Street and Number 11653 Somerset A	Avenue		10f. Zip Code 21853			_	en of What Co J.S.	untry'?
	era	11. Marital Status	12. Was Deceden	t Ever in U.S. 13		Hispanic Origin? (Sp pag, Mexican, Puerto	ecify Yes or N		4. Race - Ame	rican Indian,
		1 ☐ Never Married 2 ☐ Marrie	Armed Forces 1 X Yes 2 If Yes, Give	No	If Yes, specify Cub		Rican, etc.)	1	Black, White	
	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Specify: Whi	
	Siete	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of work	ing		d of Business/ earch	Industry
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	၉	John Melville				Winnifre				
1		19a. Informant's Name/Relationship Patricia Anne Co				t and Number or Run				
1		20a. Method of Disposition		20b. Place of Disp			Date	-	ation - City or	
		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		• [ory 02/06	/2006	Sa1i	sbury,	Md.
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a	_	fred to							Anne,	Md. 21853
I		23a. Pant. Enter the disease, or consheck, or heart failure. List or	omplications mat cause nly one cause on each	d the death. Do not e	nter the mode of dvi	an auch an andina				
			. A	ine.	_	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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	/Medic		Evelyn Waller (4a. Facility Name (If not institution, gr		r)		4b. City, Tow	n, or Location	n of Death	JANUARY		200 G inty of Death	21:01"
7 4	*		Peninsula legiona			nter	Sa	listo	14			comic	
	Funeral Director				kge (In yrs. 87	iast birthday) Yrs.	Months Da		er 24 Hrs. Min.	8. Date of Bir (Month, Da Sept. (v Vosrl	9. Birth	place (State or Foreign ntry) E•
	D.		Usual Residence of Decedent		140. 00	T							
	/arylar	ō	De. Sussex	•	Lau	y, Town or Lo	cation						10d. tnside City Limits 1 Yes 2 □ No
	r 28e-	Director	10e. Street and Number	·	Lau	161	10f. Zip Cod	le			10g. Citizen	of What Cou	
	death with the Maryland ma 23a or 28e-f show r neat the rediffed at	ra D	10949 East 4th S	t.			1	956			USA		
	be filed within 72 hours after death with the Marylan tal Hygiene. tal Hygiene. do other than "natural", or Itema 23a or 28e-f show event, tra Marical Eraphor must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 to Yes, Give Year or Dates	? X No		Was Decedent of Yes, specify C			ecify Yes or No Rican, etc.)		Race - Ameri Black, White, Bcify: Wh	
2-003p	72 hou		15. Decedent's E (Specify only highest g	ducation ade completed)		16a. Dece	dent's Usual Oc kind of work do	cupation	ost of work	ina	16b. Kind o	f Business/Ir	ndustry
7	within ene. than "	Completed	Elementary/Secondary (0-12)	Cotlege (1-4o	r 5+)		kind of work do DO NOT use re emaker	tired)		9	Home	۵	
V	e filed v	0	17. Father's Name (First, Middle, Las	t)		110III	emaker	18. Moi	ther's Name	e (First, Middle,			
=	2 should be and Mental Is marked of aumatic eve	To B	Horace Waller					Ali	ce Lo	key Wal	l1er		
a	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship Lonney H. Conowa		d	1	ng Address (Str 49 East			al Route Numbe Laure1,			o Code)
w	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		е с	emetery, crer	sition (Name of natory or other	place)		30, 200		on-City or T	
Бащтог	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice			22 H.	 Name and Adannigan	dress of Fac Short	Dish	aroon I	- Funeral		
9 7 (185) 8	Thursieinn	ļ	23a. Part1. Enter the disease, or con shock, or heart failure. List onf Immediate Cause (Final	one cause on each	line.	h. Do not ent	er the mode of	dying, such a	as cardiac	De . 199 or respiratory a			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or a	is a conseq			MORRY ERTE		. 1			
	pe sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a		uence of):	/ [1/1]	01712	142101	V			
Ď,	certificate be executed ding physicien and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a conseq	uence of):							
09/89	cate be physici s the bu	dicai	•	d									
Ď.	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 22No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	tdeath 3□	Ectopic pregna Other (specify				23d.	Date of deliv Month	ery Day Year
as,	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause	given in Par	rt 1.		obacco use c		the cause of death?
မ	2 8 8	Completed								24a. Was		prior to co	opsy findings available omptetion of cause of
	pag ate									perfo 1 ☐ Yes	2/11 No	death?	2 No
S	ysicien: is certific director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa	tient 2	ER/Outpatier	it 3□ DOA	0.1		h <i>(Check anly d</i> me 5□ Resi		Other (Speci	ń()
on or	ding Ph		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury	28b. Time or Injury	28c. I	njury at Work? 1 🗆 Yes 2		28d. Describe			<i>y</i> /
DIVISION	el or Atte s efter des il Directo id in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of I	njury - At ho etc. (Specif	ome, farm, str	eet, factory, offi	ice		28f. Location (City or To		mber or Rur	al Route Number,
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical (29a. Certifying F (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, death tion and/or in	n occurred at the vestigation, in m	e time, date ny opinion, d	and place, eath occur	and due to the red at the time,	cause(s) and date and place	manner as s	stated. to the cause(s)
	To the To the comp	X	29b. Signature and title of certifier					ense numbe			29d. Date sig		
	B		ANSW MI	7		- 00-1 T	2	1434	93		/-	27-2	004
	0		30. Name and address of person who	m.D.	100 E	CAY10	// ST.	SAL	Belly	n mo)		
20	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	iture							-
At	Registr	ar	FEB 0 6	2006	Acte .	14 6	mach s						

			- Sta	te of Maryland				•		Legible.	
			1 - State Registrar	to or mary tarre	•	tificate of		•	Reg. No.	2006	01.700
	Obveisi		Decedent's Name (First, Middle, Last)			-	1,	2. Date of De	ath Day	Year	3. Time of Death
44	Physici /Medic			itena, Sr.				Januar	y 28,	2006	1:30 a ^M
	Examin	er	4a. Facility Name (If not institution, give street a. 7518 Haines Court	nd number)			or Location of Death			County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		ince Geo	place (State or Foreign
	Director		578-42-3399 ¹ ፟≦M 2□	72	Yrs.	Months Days	Hours Min.	Feb. 2	193	3 Wash	nington, DC
land	M II		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
Many	P-f sh	tor	Maryland Prince George	e's Laur	e1						1 X Yes 2 □ No
death with the Maryland	or 28	Director	10e. Street and Number	1		10f. Zip Code			10g. Citî:	zen of What Cou	ntry?
aath w	s 23e		7518 Haines Court	- Daniel Francis II 6	140.1	20707	r		U.S.		
je j	T Item	Funeral	Am	s Decedent Ever in U.S ned Forces? !Yes 2∏No	5. 13. 1	Mas Decedent of F f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		 Race - Ameri Black, White, 	
-0036 hours after	FXE	by	3 ☐ Widowed 4 ☐ Divorced Yea	Yes 2 □ No es, Give ar or Dates: 1950 –19	954	1□Yes 2\X\\	Specify:			Specify: Whi	te
21215-0036 d within 72 hours af	nd Mental Hyglene. marked other than "naturel", or Items 23e or 28e-f show matic event, the Mudical Examilmat must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp.	leted)	16a. Deced (Give	lent's Usual Occup kind of work done	pation during most of work d)	ring	16b. Kir	nd of Business/Ir	idustry
-21215	lene.	dmo	Elementary/Secondary (0-12) Coll	lege (1-4or 5+)		cician	ω)		Fede	eral Gov	ernment
מ שון פון	ital Hygind other	BeC	17. Father's Name (First, Middle, Last)			101011	18. Mother's Nam	e (First, Middle			
Maryland de file	Menta arked atice	To	Antonio Catena				Ruth Fe	arson			
Mar 12 sh	S 50		19a. Informant's Name/Relationship (Type, Prin				and Number or Ru				•
	I o =		Della-Ann Catena - 20a. Method of Disposition	Spouse 20b. Pla		Haines (sition (Name of natory or other pla	Court, La	urel, Ma Date		and 2070 cation - City or T	
MO Pages	ent of nt: If It ry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	I IDIII SIAIG			ery Feb.	3. 2006			
Baltimore,	Department of Important: If It any Injury or o		21. Signature of Fureral Service Lyans	1201		. Name and Addre				al Home	
60 8	70 E 2 9		+out //a	4			ltimore A	venue, I	Iyatt		MD 20781
			23a. Parti. Enter the disease, or complications shock, or heart failure. List only one cause	hat cared the death e each line.	. Do not ent	er the mode of dyll	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	WHA STO	نهر	Blo	ddir C	oven			6 Morolla
E	xaminer			de to tor as a consequ	erice or).						
g	÷.	lner		ue to (or as a consequ	ence of):						
60, be executed	and Il-tran	Examiner	that initiated events	lue to (or as a consequ	ence of):						
760 e be e	nysician and he burlal-transit	calE			·						
	ng ph		IF FEMALE:								
Box eath cert	attending p	lan/	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnar Live birth 2 Fetal	death 3	Ectopic pregnanc	у		2	23d. Date of deliv Month	ery Day Year
o g	y the crowd	Physiclan/Med		Pregnant at time of de Unknown	atn 5L	Other (specify) _					
Records, P.O. Box 68 The law requires that the death certifica	been signed by the s	by Pl	Part II. Other significant conditions contributing	ig to death but not resu	lting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to t	the cause of death?
ord:	sen si							1	Yes 2[□No 3 □ Prof	bably 4 Unknown
Records,	has b	Completed						24a. Was auto		prior to co	opsy findings available ompletion of cause of
<u>a</u>			25. Was case referred to medical					1 Yes	20 No	death? 1 \(\text{Yes}	2 No
/sicia	nis certifica director, I	o Be	examiner? 1 Yes 2 No Hospital	: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	t 3 DOA Ott	26. Place of Dear ner: 4 Nursing He	4		S □Other (Speci	(6)
Vision of Vita Attending Physician:	h. After thi funeral d	T:uc			28b. Time of		ry at	28d. Describe			97
Division of Vital	tor: A the fu	catle	2 Accident investigation				Yes 2□No				
DIVI Iora	after deat Director: I in by the	Certification:	4 Homicide determined 286.	Place of Injury - At hor building, etc. (Specify)	me, tarm, str	eet, factory, office		City or To			al Route Number,
spita	within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1X Certifying Physician:	To the best of my know	viedge, deatl	occurred at the to	me, date and place,	and due to the	cause(s)	and manner as s	stated.
ths H	the Fi	Medical	A	d manner stated.	on and/or in			red at the time,		<u> </u>	
2	ZO.	-	29b. Signature and title of certifier	tam		29c. Licens				e signed (Month,	
/	(1)		30. Name and address of person who complete	d cause of death (Item	23a) (Type	D214	130		rebr	ruary 1,	2000
1	1		Michael J. LaPenta, M				, Annapo	lis, Man	ry1ar	nd 21401	
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signat	иге	R.					
	Registr	ai	FEB 0 3 2006	Com A	14						

	1	For State Registrar	State of M	laryland	-	artment of F rtificate of		and Me		iene	06	047	90
Physicia		Decedent's Name (First, Middle, La Oscar	•	11 0					. Date of Deat Month	Day	Year	3. Time of	
/Medica	1		Coghi		r.	4b. City, Town, o	vr Location o		anuary	T-	006 of Death	6:34	P. M
Examine	r	4a. Facility Name (If not institution, giv Heartland Healt of Hyattsville	th Care Co	enter			ttsvi			Princ		rges	
Funeral		5. Social Security Number 6. S	Sex 7. A	ige (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 2		Date of Birth			lace (State o	r Foreign
Director		324-22-7955 Usual Residence of Decedent	1 X 1M 2□F	81	Yrs.	Monant Bayo	110010	A	pril 4,	1924		ginia	
yland sow	<u> </u>	10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside Ci	ty Limits
B-f sh	cto	District of Colum	mbia		Washi	ington						1 X Yes	2 □ No
vith th	Dire	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cour	itry?	
eath v	Funeral Director	5219 - 5th Stree	12 Was Deceder	t Ever in 113	S 13	200		nin? (Specif	v Yes or No.	Unite	d Sta		
OUSS hours after death with the Maryland turer; or items 23s or 28s-f show all Exerrities in the rectilised at	표	1 ☐ Never Married 2X Married	Armed Forces	? No May	1943	Was Decedent of H		, Puerto Rio	can, etc.)	Bla	ck, White,	etc.	
DOG Dours :	g p	3 Widowed 4 Divorced	If Yes, Give Year or Dates	Dec.1	945	1 □ Yes 2 X No	Specify:			Speci	y: BI	ack	
Z15-0036 ithin 72 hours af ien "natural", or imudical Exem	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most	t of working		16b. Kind of E	lusiness/In	dustry	
CI Z1Z1 filled within Hygiene. wher then "	Completed	9th grade	College (1-4o	r 5+)		uck Drive				U.S.De	pt of	Army	
D = = = = =	BeC	17. Father's Name (First, Middle, Last	•				18. Mothe	r's Name (F	First, Middle, M	Maiden Suma	ne)		
aryla should the or market umatic	2	Russell Cogh						theri		ole			
ore, Maryland ss 1 and 2 should be file of Health and Mental Hy litem 27 le marked oth r other traumatic even		19a. Informant's Name/Relationship (Rose Louise Golde	en Coghill	(Wif	(0)	ng Address (Street				•			1
de a le a		Oscar Coghill, Jr 20a. Method of Disposition		20b. PI	ace of Dispo	- 5th S sition (Name of matory or other pla		Dat	9	20c. Location			.1
Page nent o nnt: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		9		coln Ceme	•	Jan.28	3,2006	Brentwo	od. l	farvla:	nd
Baltimore, permit. Pages 1 ar Department of Hea Important: If then eny injury or othe		21. Signature of Foneral Service Lice	hsee/	1/-	N I	. N. Hor	ton Co	ompany	/ Morti	cians.	Inc.	_	
205.0		23a. Part1. Enter the disease, o com	M W.	Herle	6	00 Kenne	dy Sti	reet,	V.W.;Wa	shingt	on,D.	C. 200	
Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.						231,		Interval Bet Onset and I	veen
Physician /Medical		disease or condition resulting in death)		s a consequ		ve Pulmor	nary D	iseas	e				
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entification of the second	Med	IF FEMALE:											
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ithe dy the arched	JSIC	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time of de	,a.ii	Other (specify) _							
	Dy P	Part II. Other significant conditions	contributing to death	but not resu	ilting in the u	nderlying cause giv	ren in Part I.		23e. Did tot	acco use cor	tribute to th	e cause of d	eath?
ecords, law requires t as been signe									1 □ Ye	s 2XNo	3 Prob	ably 4 □U	Inknown
	Completed								24a. Was a autops	n 24b.	Were auto	psy findings impletion of c	available ause of
m c 0										y			
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06-00684 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	of Maryla	•	artment of F		and Mental Hy	giene	16	04791
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		RICARDO ANDREW	CAREY					JANUAR	Y 27.	2006	3:35P M
1	Examin		4a. Facility Name (If not institution	, give street and nu	imber)		4b. City, Town, o	r Location o		4c. County		19.971.
1			PRINCE GEORGES	HOSPITAL	CENTER	{	CHEVE	RLY		PRINC	E GEO	RGES
	Funeral		5. Social Security Number	6. Sex XXM 2□F	2000	s. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	th ly, Year)	9. Birthp	place (State or Foreign
	Director		213 13 7191	4423 M 2 F	1	19 Yrs.			SEP. 20			YLAND
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. (City, Town or Lo	cation				1	Od. Inside City Limits
	the Marylan 28a-f show	ច	MD PRINCE	CEODOEG	CI.	TTITL AND						XX Yes 2 □ No
	the t	Funeral Director	10e. Street and Number	E GEORGES	50	JITLAND	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a or	۵	3836 REGENCY PA	ARKWAY #1	n4		20746			UNITED		*
	Jeeth Tree 2:	era	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.1	Was Decedent of H	lispanic Orig	gin? (Specify Yes or No		ce - Americ	
(0	riter	Fun	XX Never Married 2 ☐ Marr	ied 1 ☐ Yes	XIX No		f Yes, specify Cuba	an, Mexican	, Puèrto Rican, etc.)		ck, White,	
93	urs a	þ	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 💥 🗓 No	Specify:		Specia	ty: BLA	ACK
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or lleme 23a or 28a-f show tha Madical Examina must be notilled a	Completed	15. Deceden (Specify only highes	t's Education		16a. Deced	lent's Usual Occup	ation	of working	16b. Kind of B	usiness/In	dustry
21	thin thin	pje	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use retired	d)	or working			
	filed wi Hygien other th	Cor	9TH	- 30		H	IOMEMAKER			DOMES	TIC	
pu	2 should be filed within and Mental Hygiene. Ie marked other than eumatic event, the Ma	Be	17. Father's Name (First, Middle,						r's Name (First, Middle			
₹	should be ind Mental marked o umatic eve	ပ္	FLEMING ANDREW						NE ARVETTE			
Maryland			19a. Informant's Name/Relations						r or Rural Route Numb			
	1 and 2 Health em 27 other tr		LeJUNE A. STOWI	E / MOTHE		3836 Place of Dispo	REGENCY	PKWY.	#104 SU	ITLAND,		
Baltimore,	Peges nent of h int: if its iry or of		1XX Burial 2 Cremation			cemetery, crer	natory or other plac	ce)	Date	20c. Location	- City or To	own, State
ţi	t. Pertant		4 Donation 5 Other (S		RE				02/07/2006	CLINT		
Bal	permit. Peges 1 and Department of Health important: if Item 27 eny injury or other tr once.		21. Signature of Fameral Service	Consel	l	N 4	IARSHALL 308 SUIT	S FUN LAND 1	ERAL HOME C	F MARYL		
			23a. Part 1. Enter the disease, or shock or heart failure. List	complications that	caused the de							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					_	rug Wou			Onset and Death
	/Medical		resulting in death)	Due to	(or as a cons	equence of):		Chil	7			
	Examiner		Sequentially list conditions	b								
	P. 15	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	equence of):						
	and tran	Examiner	that initiated events resulting in death) Last	C. Dun to	(or as a cons	naunnan af):						
8760,	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	E III		00010	(or as a cons	equation of).						
387	phys phys the	dicai		d						_		
9 X	eath certific ettending p	Physician/Me	IF FEMALE:	23c. If yes, ou	itcome of preg	nancv				224 0	ate of delive	
Вох	eath etter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ∏ Fe nant at time of	etal death 3	Ectopic pregnancy Other (specify)	/			onth	Day Year
P.O.	that the death ed by the ette detached for	ıysı	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr								
	signed b	by Pt	Part II. Other significant condition	ns contributing to	death but not n	esulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use con	ntribute to th	ne cause of death?
Division of Vital Records,	quires n sign	D D							1_	Yes 2010	3 🗆 Prob	ably 4 Unknown
00	w requires been si	Completed							24a. Was	an 24b.	Were auto	psy findings available
Re	he lav e hes age 2				<u> </u>				auto	prmed?	prior to con	mpletion of cause of 2 No
tal	ysician: The lis certificate he director, page	ပိ	25. Was case referred to medical					26 Place	1 Nes	2□No	1 Yes	2 No
>	Physician: r this certific ral director,	To B	examiner? 17∕2 Yes 2 ☐ No	Hospital:	Inpatient 2	☑ ER/Outpatier	t 3 DOA Oth	or	of Death (Check only rsing Home 5 ☐ Resi		har (Specif	i.)
0	ng Phys ter this neral di		27. Manner of Death	28a. Date	of Injury oth, Day Year)					how injury occu		97
jo	Attending r death.	atio	1 ☐Natural 5 ☐ Pendin 2 ☐ Accident investi		7106	Found	M 1 1	Yes 2 1	No Suli	ect cut	* Stal	sped
Vis	ar de	tific	3 ☐ Suicide 6 ☐ Could determ	ined 286. Plac		home, farm, str	eet, factory, office	-	28f. Location (Street and Num	ber or Bura	al Route Number,
Ö	rs efte ai Dir ed in b	Certification:	A	Dunc	Hu		ly build	live	Sui	Haud Haud	36 6	gency Pkway
	To the Mospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the t	e best of my k pasis of exami nner stated.	nowledge, deatlination and/or in	n occurred at the tir vestigation, in my o	ne, date an pinion, dea	d place, and due to the the time,	cause(s) and m date and place,	anner as s , and due to	tated. the cause(s)
	within To th comp	Me	29b. Signature and title of certifie	r			29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
) (and	HARDO	ann	ud	0.0	M.E.		JANUARY	28 '	2006
R	13/		30. Name and address of person	who completed cau	ise of death (It	tem 23a) (Type,						
1_	9		LAKOLI	MLA	Wino	λ	111 PEN	STRE	ET BALTIMO	RE, MARY	YLAND	21201
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sig	nature						
12.	Registr	ar	FEB 03 2	UVO DE	in A	Span .						

			1- State of Maryland / Department Certification	nt of Health and M	lental Hygie	211115	04792
AT .	Physici: /Medic	an	1. Decedent's Name (First, Middle, Last) CYNTHIA CARTER		2. Date of Death Month OZ	Day Year	3. Time of Death 12:48 A M
)	Examin Funeral Director	er	WASHINGTON ADVENTIST HOSPITAL T	Town, or Location of Death AKOMA PARK or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death MoNTG (ear) 9. Birth 52 E.C.	
	Maryland f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD MONTGOMERY TAKOMA PA	10K			10d. Inside City Limits
	death with the Maryland rme 23a or 28a-f ehow r must be notified at	Funeral Director	1.517.001.01.1	20912	10g	. Citizen of What Cou	
036	be filed within 72 hours after death with the Marylan Ital Hygtene. Id other then "naturel", or Iteme 23a or 28a-1 ehow event, the Madical Extending must be notified at	þ		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	e, etc.
21215-0036	e filed within 72 hc al Hygiene. I other then "natur vent, 'ne Med Fal	Completed	Elementary/Secondary (0-12) College (1-4or 5+) ,	ual Occupation ork done during most of workingse retired) MAKER	ing 16	b. Kind of Business/I	
Maryland	should be filed and Mental Hygi marked other imatic event, I	To Be (17. Father's Name (First, Middle, Last) JOHN GEORGE CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address			BOGDANIC	H CARTER
d)	ages 1 and 2 should ant of Health and Men it: If item 27 is marks y or other traumatic			PRINCE GEO other place)	Date 20		OMA PARIC Town, State
Baltir	permit. Pages 1 Department of H Important: If ite eny Injury or of once.		21. Signature of Funeral Service Licensee 7 22. Name a	IN Address of Facility PRINCE GEORG			20912
	Physician		23a. Part Enter the disease, or complications that caused the seath. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	^	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner	- a	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	12001	*		
8760,	cate be executed physicien and sthe burial-transit	ical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of by	FIBRILLA NAL FAI		-	
P.O. Box 687	death certif e attending d for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ M6 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic; 4 ☐ Pregnant at time of death 5 ☐ Other (s			23d. Date of deliments	very Day Year
	law requires that the de es been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying PATON FALONS	cause given in Part I.		cco use contribute lo	the cause of death?
Division of Vital Records,	The ate h	Completed			24a. Was an autopsy performe 1 Yes 2	prior to c	topsy findings available completion of cause of
Zit:	sician: certific irector,) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Othor	n (Check only one)		
ion of	this ald	ation: To	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 2 Accident investigation M	OA 4 I Nursing Ho	me 5 Hesidend 28d. Describe how	ce 6 Other (Specinjury occurred	city)
Divis	i Qife	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)		City or Town, S		
	Hospital 24 hours a Funerei I letely filled	edicai	29a. Certifier (Check only one) The Cattifying Physician: To the basis of examination and/or investigation and manner stated.	I at the time, date and place, and in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the He within 24 To the Fu completel	Me	* SSHAMIM	9c. License number 59284	-	Date signed (Month	2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID SHAMIM 7606 Courroll A	re. Takoma	Park, N	10 209	12_
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID SHAMIM 7606 Couroll Ar 31. Date filed (Month, Day, Year) FEB 0 3 2006 32. Tegistrar's Signature	P			

		For State	State of Maryland	Department of I			
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of		Reg.	
Physici	an		0	C 1 1		2. Date of Death Month	Day Year 3. Time of Death
/Medi		Anita	Grace	Cunningham		ebruary	2, 2006 5:04 A M
Examir	ner	4a. Facility Name (If not institution, give s			or Location of Death		4c. County of Death
		734 Dale Avenue			erland		Allegany
Funeral		5. Social Security Number 6. Sex	M 2 XF	Months Dave		B. Date of Birth (Month, Day, Yo	9. Birthplace (State or Foreign Country)
Director		173-03-2027	87	Yrs.		8/05/191	
D >	1	Usual Residence of Decedent 10a. State 10b. County	100 City 7	own or Location			
aryla shov	L .	Toa. State Tob. County	Toc. City, 1	own or Location			10d. Inside City Limits
e W	당	MD Allega	ny	Cumberland			1 X Yes 2 No
5 th	Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Country?
th w	<u>a</u>	734 Dale Ave	nue	2:	1502		USA
dea	ner		2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Speci ban, Mexican, Puerto Ri	fy Yes or No-	14. Race - American Indian,
or Its	교	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No			cari, etc.)	Black, White, etc.
Suc since	b	3 XWidowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 汉 No	Specify:		Specify: White
id C 12.1 2-10000	Completed	15. Decedent's Educ (Specify only highest grade	ation 1	6a. Decedent's Usual Occu	pation	16	b. Kind of Business/Industry
Med T	e d	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed) during most of working	, i	
d wit	PO	12		Homemaker	_		Home
a the file	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Mai	
id be fill ental Hy ked oth	To B	Grover	Shuman		Ida		Graham
2 should be and Mental Is marked of aumatic even	-	19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Stree		Route Number. C	ity or Town, State, Zip Code)
MG 2 and 2 state of the author		Linda D. Miller /		734 Dale Ave			
paritinities, with yields ZIZIS-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, If a Medical Erachi erroral to notified at once.		20a. Method of Disposition					c. Location - City or Town, State
S S S S S S S S S S S S S S S S S S S		tXXBurial 2 ☐ Cremation 3 ☐ R	anioval nom State	e of Disposition (Name of etery, crematory or other pla			
Dealtiffication Pages Department of Mportant; If it any Injury or outce.		`4 □Donation 5 □Other (Specify)		Paul Cemetery			lear Spring, MD
Deparmit Depar Impor any In		21. Signature of Flineral Service License	•				Funeral Home, P.A.
405 e d		Lohet CC	selene	404 Decat	ur Street,	Cumberl	and, Maryland 21502
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	ations that caused the death. It e cause on each line.	Do not enter the mode of dy	ing, such as cardiac or	respiratory arrest	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Concloud X	mulas Han	dent		nset and Death
/Medical		resulting in death)	Due to (or as a consequen	EAST REAL PROPERTY.	WF V		Control
Examiner			,				
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):			
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury					
axect	xa	that initiated events cresulting in death) Last	Due to (or as a consequen	ce of):			
e be ex	call						
ficate ficate pphysics the		d					
ox ox ox ox ox ox ox ox ox ox ox ox ox o	hysician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				
ath o ath o or us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal de		cv		
the a	slc				-,		23d. Date of delivery Month Day Year
act act		1 Yes 2 No	4 Pregnant at time of death				23d. Date of delivery Month Day Year
e = 5	F.	9 Unknown	9□ Unknown	h 5 ☐ Other (specify) _			Month Day Year
Sy F es tha gned ! be det	0		9□ Unknown	h 5 ☐ Other (specify) _		23e. Did tobac	
equires that en signed I build be detr	by P	9 Unknown	9□ Unknown	h 5 ☐ Other (specify) _		_	Month Day Year
aw requires tha s been signed I	by P	9 Unknown	9□ Unknown	h 5 ☐ Other (specify) _		1 ☐ Yes 24a. Was an	Month Day Year co use contribute to the cause of death? 2 Ao 3 Probably 4 Unknown 24b. Were autopsy findings available
he law requires tha e has been signed I sge 2 should be det	by P	9 Unknown	9□ Unknown	h 5 ☐ Other (specify) _		1 Yes 24a. Was an autopsy performed	Month Day Year co use contribute to the cause of death? 2 And 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
id necolus, F.C. box oo roof out. In: The law requires that the death certificate be executed licate has been signed by the attending physician and or, page 2 should be detached for use as the burial-transit.	Completed by P	9 Unknown Part II. Other significant conditions con	9□ Unknown	h 5 ☐ Other (specify) _	iven in Part I.	1 Yes 24a. Was an autopsy performer 1 Yes 2	Month Day Year co use contribute to the cause of death? 2 And 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
vital necolos, r sician: The law requires that certificate has been signed t rector, page 2 should be det	Be Completed by P	9 Unknown Part II. Other significant conditions con 25. Was case referred to medical examiner?	9⊡ Unknown tributing to death but not resultin	h 5 ☐ Other (specify) _	iven in Part I. 26. Place of Death (1 Yes 24a. Was an autopsy performer 1 Yes 2	Month Day Year co use contribute to the cause of death? 2
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificity completely filled in by the funeral director.	Certification; To Be Completed by P	9 Unknown Part II. Other significant conditions con 25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) ilician: To the best of my knowle ter: On the basis of examination and manner stated.	of the following cause graphs of the underlying the underlying cause graphs of the underlying	26. Place of Death (ther: 4 Nursing Home any at ork? Yes 2 No 28 time, date and place, an opinion, death occurred ase number	24a. Was an autopsy performed 1 Yes 2 Check only one) 5 Residence of Describe how the Location (Street City or Town, Stat the time, date 29d.	Month Day Year Accouse contribute to the cause of death? 2
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To the Hospital or Attending Physician: within 24 hours affer death. To the Funeral Director: Affer this certificit completely filled in by the funeral director,	Medical Certification; To Be Completed by P	9 Unknown Part II. Other significant conditions con 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manuar of Death 1 Natural investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name an address erson who con	ospital: Impatient 2 ER	of the moderlying cause graphs of the underlying to the underlying the underl	26. Place of Death (ther: 4 Nursing Home ry at ork? Yes 2 No 28 time, date and place, an opinion, death occurred use number of 0.41	24a. Was an autopsy performed 1 Yes 2 Check only one) a 5 Residence of Describe how of Location (Stree City or Town, State of the time, date 1 29d.	Month Day Year Month Day Year

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Patricia Covle 24, January 2006 /Medical 1:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany County Nursing & Rehab Ctr. Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 📉 F **Director** 214-28-7037 75 10/26/1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Modical Examinal must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Forest Drive death v 21502 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3

Widowed 4

Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene, 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of perniit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked i any injury or other traumatic ev Henry Paupe Angela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard F. Coyle / son 5247 Ogilvie Avenue, Paducah, Kentucky Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donatiop 5 ☐ Other (Specify) MD Vet. Cem @ Rocky Gap 01/30/2006 Flintstone, MD 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the reach. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a CERERROVASCULAR YRJ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the sequence of the Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical use as I attending IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) eu) Ö detached 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate ! 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 2 1 🗌 Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending Injury 1 Anatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 🗌 Homicide 29a, Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29c. License number 29b. Signature, 29d. Date signed (Month, Day, Year) uls D-14867 200 6 Sanley 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J Barrera, 32. Registrar's Signature nds Barrera, M.D., 500 Memorial Avenue, Cumberland, MD 31. Date filed (Month, Day Year) JAN 2 6 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary C. Cook /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBER OF THE OF THE STATE OF T 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 217-10-7764 89 Maryland Director Dec. 13, 1916 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23s or 28s-f show the Modical Exemples must be notified at 1. Yes 2 □ No Director Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Holland St. 21502 USA filed within 72 hours after death by Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H lant: If item 27 is marked other. Be Lewis Lebeck Margaret (Burdock) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tack Cook/Son 21427 Island Club RD, Tilghman, MD 21671 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. Philos Cemetery 1/25/06 Westernport, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Physical Service 22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician A CUSTE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 250No 152Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Coertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAISH ROAD, Cumberland MD 21502 BISHOD DR. HARTIT 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

egistrar's Signature

JAN 2 4 2006

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1:30 p M **Physician** February 3, 2006 Anna Mae Cash /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5320 Dorsey Hall Drive Apt311 Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2X F Washington D.C. 8/22/1918 Director 87 218-56-4369 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location erthan "natural", or items 23e or 28a-f show Tra Medical Examiner must be notified at Ellicott City 1 ☐ Yes 2X No Md. Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 5320 Dorsey Hall Drive Apt311 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify by Specify Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10vrs Homemaker Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fill and Mental H Be Annie A. Dean James E. Hall of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n any injury or other traun Karen Napolitano/ daughter 2844 Country Lane Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St.Louis Cemetery 2/7/2006 Clarksville,Md. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Dicenses (I) MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Month Immediate Cause (Final Colon Cancer Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, flany, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yea detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 N Probably 4 □Unknown peen s Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√√2 No 24a. Was an autopsy performed? Type2 Diabetes Mellitus 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2€ No 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1X2 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56531 February 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10780 Hickory Ridge Rd. Columbia, Md. 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2006 6 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician HERBERT Month Day Year SIDNEY DUCKETT, JR. A M JANUARY 28, 2006 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 ☐ F Months 83 Director 219-01-9556 DECEMBER 1 1922 MARYLAND Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 7 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be modified at 10d. Inside City Limits 1 Yes 2 No Director PRINCE GEORGE'S SEAT PLEASANT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 716 BOOKER DRIVE 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Yes 2 f Yes, Give 2 No 1 Yes 2 No BLACK Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk GOVERNMENT 9th d 2 should be filed with and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked HERBERT SIDNEY DUCKETT SR LAURA E. JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
716 BOOKER DRIVE SEAT PLEASANT, MARYLAND 20743 FLORENCE L. DUCKETT/WIFE other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. MARYLAND VETERANS 2/6/2006 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 21. Signature, of Funeral Service Licer 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND (· D. 23a. Part1. Enter the disealer, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATHEROSCLEROTIC CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Ninknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) #MD 32453 JANUARY 31, 2006 uscost

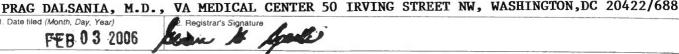
Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 0 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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	/Media		4a. Facility Name (If not institution, give				Location of Death		-	2006 County of Deat	11:20 PM
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	er de Item	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S) ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	 Race - Ame Black, White 	
36	rs aft	Jy F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify:	[]], f b -
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show ant, the Medical Experime must be multified at	Completed by Funeral	12	6	Pr	ofessor			Unde	ergradu	ate Studies
Þ	othe othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,			
/lar	uld b Ments rrked	70 E	John Arch	Wei	ntling		Nina	Mil	dred	(Cheney
Maryland	and I		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, 2	Zip Code)
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show important: if item 23 a or 28a-1 show any injury or other traumatic event, if a Medical Experimetroust be netified at once.		Nina Dunn / daugh			2 Wentlin	g Drive,	N.E.,	Cumb∈	erland,	MD 21502
Baltimore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		. Place of Dispo cemetery, crea	sition (Name of matory or other place	e)	Date	20c. Loc	cation - City or	Town, State
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	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						T. MOREN
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ă	death atte	cla	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		<pre>]Ectopic pregnancy</pre>] Other (specify)				Month	Day Year
P.O.	t the cy by the ache	hys	9 Unknown	9□ Unknown							
	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	ndertying cause give	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
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Records,	law re	Completed	Arterioscle	rotic Cardio	vascula	r Disease		24a. Was		24b. Were au	topsy findings available
Ä	iclan: The lav certificate has rector, page 2	E						autor perfo	ormed? 2 XNo	death?	completion of cause of
Vital		a)	25. Was case referred to medical				26. Place of Dea			1 3 103	20,10
of V	d is	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth		ome 5 Resi		Other (Spec	cify)
0 U			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injun Worl	/ at	28d. Describe			
0	Attending Ph or death. ector: After th by the funeral	atlo	2 Accident investigation				Yes 2 □ No				
Division	- 0 13	tif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office		28f. Location (: City or Tox			ıral Route Number,
	ital or ral D	Cel									
	Hoep 4 hot Fune ely fil	ical	(Check only 2 Medical Exam	rsician: To the best of my kiner: On the basis of exami	nowledge, deat nation and/or in	h occurred at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a	and manner as	stated. to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Certification:	Unej	and manner stated.							
	Twiff To Io		29b. Signature and title of certifier			29c. Licens				e signed (Montt	
3	14		- Juan	200/			5638		ebru	ary 3,	2006
	Miss		30. Name and address of person who o			,					
	Sta	ate.	Saturnina T. 31. Date filed (Month, Day, Year)	Chang M.D. 32. Registrar's Sig	naturo	.44	eet, Fro	stburg,	MD	21532	
	Regist		31. Date filed (Month, Day, Year) FEB 0 3 201	Jb American	J. A	0346					

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2006 Year **Physician Alberto** Del Carmen February 1, 11:43 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Naval Medical Center Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct. 29, 9. Birthplace (State or Foreign Country) Phillippines **Funeral** 1 **™** M 2 □ F Director 579-52-8557 81 Yrs Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rat', or items 23a or 28a-f show Exercise must be notified at Maryland Prince George's Ft. Washington 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 524 River Bend Road 20744 USA filed withIn 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces:
1 XYes 2 No Retired
Year or Dates: 1968 Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2KKNo þ Specify. 3 ☐ Widowed 4 ☐ Divorced Filipino "naturat" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12th Lt. Police Officer Library of Congress other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o and Mental Leoncio Del Carmen Clarita Ong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 River Bend Road Ft. Washington, Maryland 20744 Amelia Del Carmen / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 02/08/2006 Arlington, Virginia Arlington Nat. Cemetery 21. Signature Funeral Service Lipenseg 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 22. Name and Address of Facility Mas Part1. Enter the disease, or complications shock, or heart failure. List only one cays , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of): Examiner PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death signed by the all d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4xx Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No XX No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X XNo Certification: To 1 TYes 1XXInpatient 2 ER/Outpatient 3□ DOA nours after death.

Ineral Director: After this filled in by the funeral di 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 XNaturai investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0101236858 (VA) February 2, 2006 MID 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) National Naval Medical Center 0 COREY A. CARTER MC USN BETHESDA, MD 20889-5600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 04, 2006 12:00A M EARL G. DOUGLAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral XXM 2 F Yrs. JUNE 13, 1925 WASHINGTON, DC Director 579 24 6673 80 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any Injury or other treumatic event. If a Mydical Examiner in ust be notified at XXYes 2 □ No Director DC WASHINGTON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4521 NEW HAMPSHIRE AVENUE, NW UNITED STATES 20011 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XIXYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EVENING STAR 10TH AREA MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LELIA DOZIER NATHANIEL DOUGLAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4521 NEW HAMPSHIRE AVE., NW WASHINGTON, DC 20011 ERMA J. DOUGLAS / WIFE Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 02/07/2005 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart failu Immediate Cause (Final disease or condition resulting in death) 50 Physician /Medical Due to (or as a consequence of): **Examiner** demb Sequentially list conditions, 1 any localing to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner consecue or Attending Physician: The law requires that the death certificate be executed burial-transit 6 Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 No 1 Tyes 1 Yes XXNo Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \((Specify) \) 1 ☐ Yes 2 No 1 2 Inpatient 2 2 ER/Outpatient 3 DOA After thi 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation s effer dea... rel Director: Afr М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Funerel XXX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 Aruna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 FEB 0 Registrar

		•		partment of Health and Mental Hygie Pertificate of Death	2006 04817
	Physicia	, n	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	/Medic		LEO DOLOFF	February	7 4, 2006 1:10 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
-	-		Sligo Creek Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Takoma Park	Montgomery
	Funeral Director		121-22-6918 1MM 2□ F 86 Yrs	Months Days Hours Min. (Month, Day, Y	9. Birthplace (State or Foreign Country) 1919 New York
	,		Usuel Residence of Decedent		1919 New TOTK
2	show det	_	10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
¥	- Ba-	Director	Maryland Prince George's Chever1		1 No Yes 2 No
with	a or	吉	10e. Street and Number		. Citizen of What Country?
t e d	ns 23	era	3122 63rd Avenue 11. Marital Status 12. Was Decedent Ever in U.S.		J. S. A. 14. Race - American Indian,
5-0036 72 hours after death with the Maryland	"natural", or Items 23a	Funeral	1 Never Married 2 Married Married	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
030	E E	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	Specify: White
21215-0036	dical	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of working	b. Kind of Business/Industry
121	han a	Idm	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	
	Hygie ther t		17. Father's Name (First, Middle, Last)	eign Service Officer D	ept. of State
an	c eve	To Be	Charles Doloff	Sadie Zaturenski	,
Maryland	and Mental Hygiene. Is marked other than reumatic event, the M	Ë.	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rural Route Number, C	
, M.	portion. Taggor I health and Montal Hygiene. Importent: or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar mast be neithed at 200.		Liselotte Doloff - Wife 31		
Baltimore,	of He		ramatan.		c. Location - City or Town, State
imor	ent: If		I Dourial 2 Li Cremation 3 Li Hemovai from State	1/4/2	Lexandria, Virginia
Balt	Departiment any injury		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Gasch's Fun	
E 2	705 2 9		Jehrary !	4739 Baltimore Avenue, Hyat	
	100	4	23. Part1. Enter be disease, or complications that caused the peath. Do not shock or hard affice. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arrest	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	D- Allmemay all	Oliset and Death
	xaminer		Due to (or as a consequence of):		
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	*	****
petri	d	Examine	cause. Enter Underlying Cause (Disease or Idian) that initiated events C.		
0,	ician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
Records, P.O. Box 68760,	hysician the buria	dical	d		
29	attending pt	Med	IF FEMALE:		
Box	attend for us	ian/		3 Ectopic pregnancy	23d. Date of delivery Month Day Year
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G E	igned by be deta		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death?
rds,	n sign	ed by	acule anal seu	1 Yes	2 No 3 Probably 4 Unknown
Record	s been s 2 should	Completed	- ROJUCTING MID	12 CANNONE 24a. Was an	24b. Were autopsy findings available
Red Legis	ate has	шо	The contract of the	autopsy performed	prior to completion of cause of death?
		Bec	25. Was case referred to medical	26. Place of Death (Check only one)	M40 1 10 105 2 140
of Vita	ূত ত	To	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpate	tient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence	e 6 Other (Specify)
			27. Manner Feath 1 I tural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury Injury 1	y Work?	injury occurred
Sio	after death. Director: After th in by the funeral	cati	2 Accident investigation	M 1 Yes 2 No	
Division		Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street City or Town, 5	at and Number or Rural Route Number, State)
etics	neral		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, and due to the caus	e(s) and manner as stated
Division Division	within 24 hours of Yo the Funeral Completely filled	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
Tot	within comp	Ž	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
	(5)			56147	2/1/06
	5000		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	
	CX		Nasreen Mustafa Kango, M.D. 7610 (31. Date filed (Month, Day, Year) 2 32. Registrar's Signature	Carroll Avenue #205, Takoma l	Park, Maryland 20912
	Sta Registra		FEB 0 7 2006 32. Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 6:46Рм Lony Μ. DeLoach FEBRUARY 11, 2006 /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson 8. Date of Birth (Month, Day, Year) Mar. 1, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖸 F 85 Director 457-52-6632 Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "netural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits MD Harford 1⊠Yes 2 No Director Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 Graceford Drive 21001 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ANo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White <u>ک</u> 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker In home other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 Is marked oth eny injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be Adolf May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Linda DeLoach Banta (Daughter) 523 Southport Lane, Kemah, TX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 2/28/06 Arlington, Virginia 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 -Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner SEVERE AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Hospital or Attending Phyalcian: The law requires thet the death certificate be executed CORONARY ARTERY DISEASE Due to (or as a consequence of) Box 68760, Physician/Medicai ₽ 2 ste has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 TYes 1 ☐ Yes : After this certification of funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after dea... ral Director: Aftr 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) m-chia W.O. 1 D 41410 2006. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE, TOWSON, MARYLAND 21204 MEHTO M.D. 7

Registrar's Signature TOGINDER F 7601 31. Date filed (Month, Day, Year) FEB 1 2006 State Registrar

Amend item#19a, per line, Type 2012 Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 805 M WOJEWSKI 2000 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1219 Old Mountain Road South Joppa Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 2 (Month Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**☐M 2☐F 90 Pennsylvania 215-12-9255 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Harford Joppa the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1219 Old Mountain Road South U.S.A. 21085 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours efter 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1937-39 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: White 3√ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter 12 U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Dwojewski Victoria Karian Daniel M. Dwojewski (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 210 Bush Chapel Road Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 2/21/06 West Chester, PA 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EREBRAL VASCULAR /Medical Due to (or as a consequence of): Examiner PHERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the attending phed for use as use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown ERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. i Director: After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) Medic 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 155143 m 1021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARL SPECTOR, MD
31. Date filed (Month, Day, Year) BELAIR, MD ZIOIS RI TOLLGATE 2014 State FEB 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink, Fraure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nb. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 31 JANUARY WILLIAM EBRON 2006 8:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat PRINCE GEORG'S UPPER MARLBORO 9610 MUIRFIELD DRIVE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 17 9. Birthplace (State or Foreign Days Months Min. 1 X M 2 □ F Hours 230-22-1444 91 Yrs. NORTH CAROLINA 1914 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9610 MUIRFIELD DRIVE 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No f Yes, Give Year or Dates: Specify: BLACK 8 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th CONSTRUCTION PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALICE ROBINSON JOHN EBRON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9610 MUIRFIELD DRIVE UPPER MARLBORO, MARYLAND 20772 LONNIE M. EBRON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 2/7/2006 CLINTON, MARYLAND 21. Signature of Funeral Scrutta Thensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 29e Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DENTILU < WEMG x WYD GLCG 1 EN A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performe 1 ☐ Yes 2/3 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month) Day, Year)

Examiner Box 68760 o Records, P. Division of Vital

burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed physicien the 950 ò detached Sec paga director this After death. l Director: A within 24 hours e To the

Physician

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il Hygiene. other than "naturel", or iteme 23e or 28a-f ehov vent, itte Modical Examiner must be notified at

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event one.

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Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Ye FFR 0 7 2006 Year) State FEB07 Registrar

29b. Signature and title of certifier

29a. Certifier (Check only

32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.1)

BRADLEY JOSEPH EBERSOLE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10 a-c.e.f. per 1h 9853 3-20-06 vt. State of Maryland Department of Health and Mental Hygiene 06-00873 RJ1 - For State Registrar 04806 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Bradley Joseph EBERSOLE 2006 February 4, 9:31 a. м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Route 40 West Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F 058-68-9583 Director 26 July 9, 1979 Washington, D.C Usual Residence of Decedent with the Maryland 10a, State 10b. County Washington 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f ahov any Injury or other traumatic event, the Mudical Examinar must be notified at once. Williamsport Directo emisylvania · Franklin. Mercersburg 1 ☐ Yes 2 No 10e. Street and Number 11615 Pinesburg Rd. 21785 10f. Zip Code 10g. Citizen of What Country? 14953 Secrist Road 17236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ò plumber commercial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Dean Ebersole Patti Anne McCarthy ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy D. Ebersole - father 14953 Secrist Rd., Mercersburg, Pennsylvania 17236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State cometery, crematory or other place)
Salem Reformed Church 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/06 4 Donation 5 Other (Specify) Hagerstown, Maryland Cemetery 21. Signature of Furnish Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME kerned 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** InjuliE! /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): ettending physicien for use es the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 200 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

▼S Yes 2 □ No Yes Yes 2□ No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) At scene ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide 4/06 91.20 AM investigation 1 ☐ Yes 2 ☑ No Director: DVICE Auto involved in collidian 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Ruff 40 west 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours efter To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Chack only one) Med 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 5, 2006 ed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 sAcu 5H-3

State Registrar 31. Date liled (Month, Day, Year)

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	Stat	2	30. Name and address of person with the control of	D. KURG				Penr	Stre	et E	Baltimo	ce,M	arylan	d 2120	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) FALWELL-SHAW LOIS JANUARY 29 2006 7:36 P 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 ☐ M 2 🖾 F 61 27 SOUTH CAROLINA September 251-86-3944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1. Yes 2 □ No PRINCE GEORGE'S FT. WASHINGTON MD

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow solcal Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funerai

10e. Street and Number

12606 PRESTWICK DRIVE

Funeral

Director

Physician /Medical Examiner

anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the a within 24 hours a To the Funeral [

Division of Vital Records, P.O. Box 68760,

Funer	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, sp	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	
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To Be Completed by Funer	17. Father's Name (First, Middle, Last) WILLIAM SEABROOK				Name (First, Middle, Maide ADYS GRAHAM	en Sumame)	
_	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Addre	ess (Street and Number or	Rural Route Number, City	or Town, State	Zip Code)
	WILLIAM N. SHAW/HU	SBAND	12606 PR	ESTWICK DR.	FT. WASHING	TON, MARY	LAND 20744
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	resulting in death)	Due to (or as a consequence of the Soul V	ience of):	1 Faul	une		
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Ö	25. Was case referred to medical			26 Place of I	1 ☐ Yes →	No 1 Y	35 242 110
o B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	ER/Outpatient 3	Other	g Home 5 Residence	6 ☐Other (Si	pecify)
tion: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
ertifice	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	tory, office	28f. Location (Street City or Town, Sta	and Number or ate)	Rural Route Number,
Aedicai Certification: To Be	29a. Certifier Certifying Physical Control (Check only one)	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death occurr tion and/or investigati	ed at the time, date and plion, in my opinion, death o	ace, and due to the cause courred at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
Ae	and an end the of continue			20- Learner Sumber	1 -04	Data sissand /44s	net One Vanal

ted cause of death (Item 23a) (Type, Print)

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State

Registrar

30. Name and address of perso

31. Date filed (Month, Day, Year)

FFB 0 3 2006

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#29d. PerPhys. PGC 2-16-06cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician FEBRUARY 03, 2006 RENEE FLOYD 4:25P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M **X**XF Yrs. Director 577 74 2938 20, 1952 53 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23a or 28a-1 ehow the Medical Examiner must be notified at 1XXYes 2 □ No MD PRINCE GEORGES SUITLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3926 SUITLAND ROAD #203 20746 UNITED STATES Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Maryland 21215-0036 1 Yes XX No Specify: Specify: BLACK ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed to Depertment of Health and Mental Hygie important: if item 27 is marked other tile eny injury or other treumatic event, that page. 12TH SECRETARY USDA / FED. GOVT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 HEZEKIAH COLEMAN ARLENE STALEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALZEN TYRONE FLOYD / HUSBAND 3926 SUITLAND RD. #203 SUITLAND, MD 20746 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 02/08/2006 BRENTWOOD, MD 21. Signature of Fune al S 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. SUITLAND, MD 20746 4308 SUITLAND ROAD enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. GASTROINTESTINAL BLEEDING /Medical Due to (or as a consequence of): Examiner b. METASTATIC PANCREATIC CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) transit. law requires that the death certificate be executed and Due to (or as a consequence of): physicien a s the burial-Box 68760. Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes XX No
9 ☐ Unknown Day Year 5 Other (specify) signed by the e Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably ▼ ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2√√No director. 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: XX Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 Yes 2 No 4 hours after death Funerei Director: / death 2 ☐ Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide ö filled in the Funerei **CXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical etely (Check only within 24 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) February 05, 2006 D62571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. BROMELANO, M.D. 1500 FOREST GLEN RD. SILVER SPRING, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Aν 6:35 Mary Ellen Flury 2, 2006 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 17, 1939 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Washington, DC 1 □ M 2 🕅 F Yrs. 66 217-36-5383 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2☐No Maryland Anne Arundel Davidsonville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3315 Royale Glen Court 21035 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after in Hygiene.

Other than "natural", or Itel 1 ☐ Yes 2001No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3√Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner Tailoring 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If Item 27 is marked oth Be James Timothy Parker Alice Amelia Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marvin Presley/son 3314 Gapland Road Rohrersville, Maryland 21779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: if ony injury or once. 4 □Donation 5 □ Other (Specify) 2/4/2006 Lakemont Mem. Gardens Davidsonville, MD of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AGNOVENIC MYEROND **Physician** YLARS METAPLASIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, iclan/Medical attending physic for use es the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 SNo Month Day 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 2 No 2 No 1 Yes 1 ☐ Yes rs after deam...
rel Director: After this cerus...
ris by the funeral director, p. To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel C completely filled Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) death (Item 83a) (Type, Print) 30.\Nan ENGRAUNA ODE COS 31. Date filed (Month, Day, Year) State FEB 0 3 2006 Registrar

		•	For State Registrar	State of	Marylan	-	artment of H		nd Mental Hy	giene	16	04811
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Elaine C. Fi	elds					2. Date of Dea Month		Year	3. Time of Death 4:40 P M
	Examin		4a. Facility Name (If not institution, give s Atlantic Gene	ral H	05017	tal	4b. City, Town, or Ber	110			rce	
	Funeral Director		5. Social Security Number 6. Sex 064-12-2148	M 2K) F	Age (In yrs. 97	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Birt (Month, Da June 20	y, Year)	9. Birthp Cour Virgi	place (State or Foreign ntry) inia
	ith the Maryland or 28a-f show e natiling at	tor	10a. State 10b. County Maryland Worcester	•		y, Town or Lo	ocation			<u>-</u>	1	10d. Inside City Limits 1 Yes 2 X No
	th with the 23s or 28s	i Direc	10e. Street and Number P. O. Box 799			JO1 1111	10f. Zip Code 21811			10g. Citizen of \	What Cour	ntry?
36	or Items	by Funeral Director		12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give	es? No		Was Decedent of H	ispanic Origi in, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Rac	ce - Americ ck, White,	etc.
Maryland 21215-0036	hin 72 hours b. n "natural", Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade	Year or Date cation completed) College (1-4		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most i	of working	16b. Kind of B	Bla	
d 212	filed withir I Hygiene. other then ent, ILe Me	Be Com	17. Father's Name (First, Middle, Last)	4+		Secr	etary/Book		r s Name (First, Middle,	NAACP Maiden Surman	ne)	
ıryları	2 should be filed vand Mental Hygie is marked othar raumatic avant, IL	To B	John S. 19a, Informant's Name/Relationship (Tv)		Coulbo		ng Address (Street	Hele	en or Rural Route Numbe		aters	a Code)
re, Ma	s 1 and 2 s f Health ar Item 27 is other trau		David Briddell/ner he	W	20b. P	356 M		enue -	Englewood		7631	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic: once.		1 🖫 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License		ale	Paul U	MC Ceme 2. Name and Address	tery 0	2/11/2006 1213 Jerse	y Road ·		isbury, MD
	Physician		23a. Part1. Exter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	<u> </u>	used the deat th line.				AL CHAPEL ardiac or respiratory ar			Approximate Interval Between Onset and Death
174 2006 14/2006 8760,	Medical Examiner physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conse	y at Jence of):	heroscle	erotic	, heart o	liseas	e	gears
74B 2.0. Box 6	The law requires that the death certific tite has been signed by the attending p bage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Avo		th 2 Feta	Ideath 3[Ectopic pregnancy Other (specify)				te of delive	ery Day Year
gg Sp	w requires that been signed b should be deta	ed by Pt	Part II. Other significant conditions con	Inbuting to dea		ulting in the u	nderlying cause give	en in Part I.	23e. Did to			he cause of death? pably 4 []Unknown
I Reco		Complet	hypertensio	20					24a. Was autor perto 1 Tes	rmed?	prior to co death?	ppsy findings available impletion of cause of
ine (ding Physician: Th n. Affer this certificate funeral director, pag	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Manner of Death 1 Natural 5 Pending	ospital: 1 Unp		ER/Outpatie		er: 4 🗆 Nurs	of Death Check only of sing Home 5 Resident 28d. Describe h			ý)
E) control	or Attendation death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined					Yes 2□N		Street and Numb vn, State)	er or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Lertifying Physics (Check only one) 2 Medical Examin	vician: To the base ner: On the base and manne	is of examina	w/edge; deat tion and/or in	h ecounge at the lift vestigation, in my o	odale trid pinion, death	place and disarro the occurred at the time,	causo(s) and ma date and place,	and due to	tated. the cause(s)
	withii Comp	Σ	29b. Signature and title of certifier Kustule Signature							29d. Date signe.		Day, Year)
6	my	10	30. Name and address of person who co KRISTINE GRIFF	IN MI	0 120	39 CU	Print) ASTAL /-	116110			-	NO, DE 1994
	Sta Registr		31. Date filed (Month, Day Year), 20	06 32. 100	gistrar's Signa	ture J. A	partis					

			T = For State Registrar	State of I	Maryland		artment of H tificate of I			Reg. No.	04812
ı	Physici /Medic		1. Decedent's Name (First, Middle, Shirley Ar						2. Date of De	1 Day 200 bear	3. Time of Death 4:15A M
	Examir		4a. Facility Name (If not institution, Kline Hospice		er)		4b. City, Town, or Mt • A		Peath	4c. County of Deal	erick
	Funeral Director		5. Social Security Number 335-30-9384	5. Sex 1 □ M 2 🔀 F	Age (In yrs. Ia 70	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bird Min. Jan •	1.0° 1936 Co	hplace (State or Foreign
	aryland show		Usual Residence of Decedent 10a. State 10b. County MD Fred	lerick	10c. City	, Town or Lo	cation iddletov	vm			10d. Inside City Limits 1X Yes 2 □ No
	vith the M or 28e-f	Directo	10e. Street and Number 1 Lombardy Dr				10f. Zip Code	L769		10g. Citizen of What Co	
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event. It a Medical Exactinar must be notified at ODGs.	by Funeral Director	11. Marital Status 1 □ Never Married 2 📉 Marrie	12. Was Decede Armed Force	s?				? (Specify Yes or No querto Rican, etc.)	- 14. Race - Ame Black, Whit	
Maryland 21215-0036	nin 72 hours in "neturel", Medical Exp	Completed by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Date		16a. Deced	dent's Usual Occupa kind of work done o	ation during most of	working	16b. Kind of Business/	
1d 21	e filed with	Ве Сош	12 17. Father's Name (First, Middle, La			se	cretary		Name (First, Middle,		ducation
arylaı	should band Ments s marked umatic e	To	Joseph Naumar	o (Type, Print)		19b. Mailir	ng Address (Street a	and Number o	lle Boeh	er, City or Town, State, 2	Zip Code)
re, M	s 1 and 2 of Health is item 27 i		Donald Full (20a. Method of Disposition		20b. Pl	ace of Dispo	ombardy sition (Name of natory or other place		Date	own, MD 2.	
Baltimore,	mit. Page bartment o bortant: if r injury or		1 Department 2 Cremation 3 1 Department 5 Other Special Service 1	icity)		forme	d Cemete	ery 2/		Middleto	
Ä	P. P. P. S.	(23a. Part). Enter the disease, or c	omplications that caus	sed the death					neral Home etown, MD	21769 Approximate Interval Between
	Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	$_{a}$ \bigvee exte		pan	creatic	carci	inoma		Onset and Death
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8760,	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ence of):					
.O. Box 68	the death certify the attending ched for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		n 2 ☐ Fetal tat time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
S,	se us	by	Part II. Other significant condition	s contributing to deat	h but not resu	ilting in the ui	nderlying cause give	en in Part I.		obacco use contribute to	the cause of death?
Record	The law ite has b	Completed							24a. Was autop perfo	an 24b. Were au prior to death? 2XXo 1 Yes	Itopsy findings available completion of cause of
fVital	iding Physicien: Th th. : After this certificate s funeral director, pag	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 🗆 E	ER/Outpatien	t 3 DOA Othe	or.	Death (Check only c		Hospice
Division of	tea tor the	Certification;	27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t he		28b. Time of Injury	M 1⊟	yat k? Yes 2∏No		now injury occurred Street and Number or Ri	ural Route Number
DİV	or afte Dir		4 Homicide determin	building	etc. (Specify	")	eet, factory, office		City or Tov	vn, State)	
	To the Hospitei within 24 hours a To the Funerel completely filled	Medical	(Check only 2 Medical E.		s of examinati		vestigation, in my of	pinion, death o	occurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
7	Veitl To	4	29b. Signature and title of certifier	> <		3 M	29c. License D140			29d. Date signed (Mont 2/3/06	u, way, rear)
	6		30. Name and address of person w P G Rausch, I	no completed cause $MD = 501 \ V$	of death (Item 7 7 th	23a) (Туре, ST F	_{Print)} redericl	k MD	21701		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0	6 2006 Reg	Grar's Signat	ture	Specker				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 6, 2006 **Physician** ELIZABETH MAY FOGWELL 21:55 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 12, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2∏F 93 DE 220-78-6716 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a nr 20a 1 any injury or other traumatic avenue. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No WORTON Director KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11128 OLD WORTON ROAD 21678 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EUGENE THOMAS ELSIE THOMAS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH STEVENS/PERSONAL REP. 11128 OLD WORTON ROAD, WORTON, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTER CEMETERY FEB. 9,2006 CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Kick of 23a. Part 1. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) O Cand **Physician** 5 days /Medical Due to (or as a consequence of) Examiner erios clad 10 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy certificate 1 Yes 20 NO or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one, Certification: To Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient 1 Yes this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan KRES UD 516 Wes hing fm Clastaton 31. Date filed (Month, Day, Year) 32. Registrar Signature State 0 2006

DHMH 17 Rev 1/2001

Registrar

FEB

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2/9/06 mp Certificate of Death Rag No. State cchd Registrar Amend item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Lillian /Medical Farmer January 31,2006 10:50PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brandywine Charles 15245 Regina Drive 7. Age (In yrs. last birthday)
80 Yrs. Months Days Hours Min. Aug. 02, 1925 Maryland 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Director 216-22-2983 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If st M. Jurial Examinar. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Charles Brandywine Director 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15285 Makle-Hayden Pl. 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Custodian DC Villiage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hayden Makle Mary E. Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Farmer, Jr./Son 7505 Branch Alley Pl. Marbury, MD 20658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD. Veterens Cem. `4 ☐ Donation 5 ☐ Other (Specify) 2/7/06 Cheltenham, MD 21. Signature of Juneral Service Licensile 22 Name and Address of Facility
Adams Funeral Home, PA 20605 Aquasco, Aguasco MD 20608 23a. Part1. Enter he disease, or com shock, or heart failure. List only vications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on some on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 Yes 20 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home - Residence 6X Other (Specify brother's 1 ☐ Yes 2 ☐ No Certification: To After this funeral dii 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, Director: 24 hours a To the

> State Registrar

cai

31. Date filed (Month, Day, Year) FEB 0 6 2006

29b. Signature and title of certifier

4 Homicide

29a. Certifies (Check only one)

> 70 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		ı.	For State Registrar	State of	Maryland		artment of F				ene	06	04815
			Decedent's Name (First, Middle, Last)			-				Date of Death			3. Time of Death
	Physicia		Jacqueline	E. G	Garrison			•		Month January	29,	2006	7:40p M
	/Medic Examin		4a. Facility Name (If not institution, give str.	eet and numb	ber)		4b. City, Town, o	r Location				nty of Death	
			13009 Boykin Place				Upper 1	Mar1b	oro		Pri	nce Ge	eorges
	Funeral		5. Social Security Number 6. Sex		. Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, Y	'ear)	9. Birth	place (State or Foreign intry)
	Director		3,0 ,1 3211	1 2 X F	52	Yrs.			No	ov. 30,1	953	Washi	ington,D.C.
	and W		Usual Residence of Decedent 10a, State 10b, County		10c. City, 1	Town or Lo	cation						10d. Inside City Limits
	f sho	ō	Maryland Prince Geo	****	IIn	nor N	law 1 hawa						tX☐Yes 2☐No
	the t	ec.	10e. Street and Number	Iges	op)	per r	larlboro			100	. Citizen o	of What Cou	intry?
	3a or	Funeral Director	13009 Boykin Place				2077	4				ed Sta	-
	ms 2	Jera			ent Ever in U.S.	13.	Was Decedent of H	lispanic Or	igin? (Specify	y Yes or No-	14. R	lace - Ameri	can Indian,
9	after or Ite		1 Never Married 2 ☐ Married	Armed Forc	X No		If Yes, specify Cubi			an, etc.)		lack, White,	
8	rel', o	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes 25€ No	Specify:			Spec	cify: Bla	ick
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show te Modical Exercities mast be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	1	6a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	st of working	16	b. Kind of	Business/In	ndustry
2	vithin ne. han	пр	Elementary/Secondary (0-12)	College (1-4	4or 5+)						_		
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	3		rer	sonnel O			First, Middle, Ma		rnment	
anc	I be find Hed of	Be	Aaron Crouch							e Smith		airi o)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene and Mental Hyglene le marked other than "naturel", or litems 23a or 28a-1 show an marked other than "naturel" can all be natified a aumatic event, it a Maalical Examinating and	은	19a. Informant's Name/Relationship (Type	Print)		19b. Mailir	ng Address (Street					vn. State. Ziu	n Code)
\mathbf{Z}	lith ar 27 le r trau		Aaron Crouch / Fat				0 Excalil					2071	
<u>6</u>	f Hea f Hea item othe		20a. Method of Disposition	ner	20b. Plac	e of Dispo	sition (Name of matory or other place		Date			n - City or To	
E O	Page ient o nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	noval from St			Memorial	F	eb. 4,	2006 L	andov	ør, M	ld.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 le marked any injury or other traumatic es once.		21. Sign Jure of Funeral Service Censee	_	10100-	22	ANeme and Adde 5538 Mar	ss of Facili	Pare	uneral Foresty	Homes	Md.	·• 20747
	40340		23a. Part1. Enter the disease, or complica		101 PRS							,	Approximate
	No.		shock, or heart failure. List only one	cause on eac	ch line.						.,		Interval Between Onset and Death
	Physician /Medical	i I	disease or condition resulting in death)	_			lypertens	ive H	leart D)isease			
	Examiner			Due to (or	r as a consequer	ice or).							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequer	ice of):							
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8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	i Ex	resulting in death) Last	Due to (or	r as a consequer	ice of):							
87	cate I physi the t	dicai	d										
9 ×	ding	/Me	IF FEMALE:	If yes outco	ome of pregnancy	,					204.5	Data of dalis	
Вох	leath certific attending p	Physician/Me	in the past 12 months?	1 Live birt	th 2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	/				Date of delive Month	ery Day Year
o.	that the de ad by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow		0							
<u>α</u>	es that the igned by be detact		Part II. Other significant conditions contri	buting to dea	th but not resulting	ng in the u	nderlying cause giv	en in Part I	l.	23e. Did toba	cco use co	ontribute to t	he cause of death?
Records,	requires that een signed b nould be deta	d by								1 ☐ Yes	2 🗌 No	3 🗆 Prol	babiy 4 XIUnknown
Ö	× 0 0	iete								24a. Was an	241	o. Were auto	opsy findings available
	The lav ate has page 2	Completed								autopsy performe 1 ☐ Yes 24	d? I No	prior to co death? 1 \(\sum \text{Yes}	mpletion of cause of
Vital	ician: certifica rector, p	a	25. Was case referred to medical					26. Place	e of Death (C	Check only one)	3 140	1 1 1 1 1 1 1 1	
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ioi	Attending r death. ector: After by the fune	atic	2 Accident investigation	,		,,		Yes 2	No				
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	Hospitel (4 hours a Funerel D		00- 0-4/ 4/- 0-4/ Physic		-1-1111	Mars - 4 4							
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examine	r: On the bas and manne	is of examination	and/or in	vestigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred a	at the time, date	se(s) and place	nanner as s a, and due to	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	11	/		29c. Licens					ned (Month,	
)			throw 1	thest	Z-DO		H.	205	1827	>	Tels	ung.	1 2006
1	(8)		30. Name and address of person who	_	of death (Item 23	Ba) (Type,	Print)	ale d	B	,		/	/ 2006
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			1 - For State Registrar	State of	Marylan		artment of F				iene 0 0	6 04816	
3ν - ξ	S		Decedent's Name (First, Middle, La	ast)					2.	Date of Deat	th	3. Time of Death	
	Physici /Medic		Robert Lee (Gibson					Jo	nualy	27 20	9:50 F M	
	Examin		4a. Facility Name (If not institution, gir		oer)		4b. City, Town, o	r Location o	of Death	1	4c. County of		
4			Doctor's Hosp					Lanhar				nce George's	
г	Funeral Director			Sex 7. 1 X M 2□ F	. Age (In yrs.		If Under 1 Year Months Days	Il Under Hours	Min.	Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)	
And a			227-14-6620 Usual Residence of Decedent			i3 Yrs.			l l	lar. 3,	1952	Virginia	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	Ba-f.	ctor	Maryland Prince	George's				Lanhar	m			1 XYes 2 No	
	ith th	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen ol Wh	nat Country?	
	a 23a	Funeral	9204 Morley			0 100		2070				ed States	
	item item	une	11. Marital Status 1 ☐ Never Married 2 ☐ ★ Married	12. Was Deced Armed Forc 1 Yes 2	es?	. S. 13.	Was Decedent of H I Yes, specify Cub	an, Mexicar	n, Puerto Ric	y Yes or No- can, etc.)		- American Indian, , White, etc.	
336	urs af	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2XX No	Specify:			Specify:	B1ack	
Ö	within 72 hours after death with the Maryland ene. then "neturel", or itema 23a or 28a-f ehow ta Medical Exeminat must be rootlied at	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occup	ation	t of working		16b. Kind of Bus	iness/Industry	
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and	od I H	Be	17. Father's Name (First, Middle, Las	()				18. Mothe			Maiden Sumame,	,	
Maryland 21215-0036	d Mer d Mer mark	²	Roy Edwards 19a. Informant's Name/Relationship	(Type Print)		19h Mailir	ng Address (Street	and Numbe			Gibson	(tate Zin Code)	
<u>8</u>	nd 2 s lth an 27 io 1 trau		Josephine Gibso			1	0 Lorrin						
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural; or itema 23a or 28a-f show enyl figury or other traumatic event. The Medical Examinat must be notified at ance.		20a. Method of Disposition		1 0	Place of Dispo	sition (Name of natory or other plai	cal	Date	Э	20c. Location - C	City or Town, State	
Baltimore,	Page nt: if ry or		1 ABurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ate	-	Memorial	,	2/4/2	006	Lando	over, MD	
ati	permit. Departmimporte importe eny inju		21. Signature of Funeral Service Lice	nsee A			. Name and Addre				uneral H		
m	88 58		John S	terrail	III		4001 Benr	ning F	Rd., N	.E. Wa	sh., DC	20019	
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89	leath certifica attending ph I for use as th	Med	IF FEMALE:										
Вох	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	ildeath 3 [Ectopic pregnancy	,			23d. Date Mont		
0	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	ntattime old vn	leath 5□	Other (specify)				MORITI Day 19a1		
۵.	that the death cert led by the attendin detached for use		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying cause gry	ren in Part I.		23e. Did tot	pacco use contrib	oute to the cause of death?_	
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00	w requires been si	lete	ACUTE RENI	AL FA	ILVEE					24a. Was a	n 24b. We	ere autopsy lindings available	
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<u>ra</u>	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical	THE				26. Place	of Death (C	Check only on		3163 2016	
<u>></u>	Physic this ce	To	examiner? 1 Yes 2 6	Hospital: 1 Min	oatient 2	ER/Outpatien	t 3□ DOA Ott	ier: 4 🗌 Nu	ırsıng Home	5 🗌 Reside	ence 6 Other	(Specify)	
Division of Vital Records,	ding Ph h. After th funeral	on:	27. Manne Death 1 Latural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	Wor			d. Describe ho	w injury occurred	d	
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	the Ho nin 24 h the Fur	edical	one) 2 Medical Exa	miner. On the bas and manne	is of examina	ition and/or in	vestigation, in my o	pinion, dea	ith occurred	at the time, d	ate and place, an	nd due to the cause(s)	
	To the Within To the	Me	29b. Signature and title of centrier	/			29c. Licens	e number		2	9d. Date signed	(Month, Day, Year)	
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R	131		30. Name and address of person who	1 6.11		1			,		\$ 20704		
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1000	Sta Registr		FEB 0 6 200	S ALCON		Span	W						

		1 - For State Registrar	State of Maryla	nd / Depa	artmen	it of Hea	ılth and I		•	916 (14818
		Registrar 1. Decedent's Name (First, Middle, Last,	1	Ce	niiicat	e of De	atn	0 D-44D-	Reg. No.		7010
Physi	ician	ANN M.	Gintz					2. Date of De Month	Day	Year	3. Time of Death
	dical	4a. Facility Name (If not institution, give	street and number)		4b Ciby	Tourn or Los	ation of Death	02	03	1 Documenty of Death	9:35 1
Exam	niner	Coxtx Hospic		Ste	40. City,	110		1	11/	COW	100
Funera	al	5. Social Security Number 6. Sec		last birthday)	If Under		Under 24 Hrs.	8. Date of Bir	th		
Directo	_	204-24-9025	M 2 🔏 73	Yrs.	Months	Days H	ours Min.	April 0	0,1932	Penn	ace (State or Foreign lry) sylvania
yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10	Od. Inside City Limits
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er de	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Dece	dent of Hispar offy Cuban, M	nic Origin? (S lexican, Puert	pecify Yes or No o Rican, etc.)	14. R	ace - America lack, White, e	
s aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 🗆 Yes	2 No S	pecify:		Spec	oity: Whit	
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D - 7 2 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b.	Place of Dispo cemetary, crei	osition (Nar	me of other place)	1	Date		n - City or To	
nit. Pages artment of ortant: if it		4 Donation 5 Other (Specify)		rnwood			2/08	/06	Fernwo	od, Pe	nnsylvania
Daltimor permit. Pages Department of I important: if its eny injury or or	SUC S	21. Signature of Funeral Service Licens	eland. (F)	0	ollov Ol Sr	Vayr¶ui now Hi	feral F	Home P.A Salisbu	ry, Mar	ryland	21804
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A STATE OF THE STA	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	juence of):		,)				
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death cer e attendir of for use	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet:	al death 3[Ectopic pr					Date of deliver Month	ry Day Year
, 9 ef	yslo	1 ☐ Yes 2.12 No 9 ☐ Unknown	4□Pregnant at time of a 9□ Unknown	death 5	Other (sp	0ecify)					,
res that the disigned by the		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying c	ause diven in	Part I	23e. Did t	obacco use co	ntribute to the	e cause of death?
Ords, Frequires that seen signed be deta	d by	1.4.3	RTENSIO		, ,			10	<i>A</i> *		ibly 4 ⊟Unknown
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Of VITA Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	fospital:	Ten in		Other		th Check on			
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or or ding Phy th. After thi funeral o	후	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	Work?	2 🗆 No	200. 20001128	now injury occ	ulled	
INTESTOR or Attending after death. Director: Alter in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, str				28f. Location /	Street and Nur	nher or Rural	Route Number,
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To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medicai C	2 Induical Exami	sician: To the best of my kn	owledge, deat ation and/or in	h occurred vestigation	at the time, d	ate and place	, and due to the	cause(s) and a	manner as sta	ited.
To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.			. License nui			29d. Date sign		
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		20 Name and Addition to	ompleted cause of death (Ite		2		425		77	100	in
		30. Name and address of person who co	16 AACS	m 23a) (Type,	Print)	ILE	12 /	H65-111	RIPU	1 Acis	2/50/
Age Land	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	-10	111-10	7_3 -	7(47	12010)	/ /	2,00/
Regis		FEB 0 6 20	006	H A	La N	Æ					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February Tracy Lorraine Miller Green 2006 10:40P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number 9. Birthptace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** 215-52-6885 1 □ M 2 🛱 F 57 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location s 23a or 28a-f ehow 10d. Inside City Limits Maryland Montgomery Ashton Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18404 New Hampshire Avenue 20861 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: þ White Specify: 3 Widowed 4 Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Prince George's Co. School System College (1-4or 5+) permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: if Item 27 is marked other the eny injury or other traumatic event, the one. School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maynard Tracy Hinton Ellen Elizabeth Via 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Green -Husband 18404 New Hampshire Avenue Ashton, Maryland 20861 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 2/6/2006 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA onald 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physicien and use as the burial-transft death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetat death 3 Ectopic pregnancy in the past 12 months? Year 4☐ Pregnant at time of death Month Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cete has been sig , page 2 should b 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy is after deam.
Ital Director: After this cerus.
Ital by the funerel director, p? 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specific Spice 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitei or within 24 hours after To the Funeral Dire completely filled in b ö 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) WO February 2, 2006 D35635 who Completed cause of death (Item 23a) (Type, Print)
MD 6001 Muncaster Mill Road Rockville, Maryland 20855 30. Name and address of person Joseph Kaplan, 31. Date liled (Month, Day, Year) 32 Registrar's Signature State FEB 0 3 2006 Registrar

Gwen D. Gregory Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27, penff.,033,3/6/06 IT State of Maryland / Department of Health and Mental Hygiene 06-00983 CTCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gwen Doelyn Gregory February 07 2006 5:59 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10803 Glade Court Frederick New Market 8. Date of Birth (Month, Day, Year) Tan. 31, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💯 F 59 Director 227-60-2001 Yrs. Ĩ947 Usual Residence of Decedent the Maryland 10a. State t0b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland 1 Yes 2 No Frederick New Market Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ітете 23а 10803 Glade Court 21774 S. A. death Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ÑNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Heelth and Mantat Hygiene. Int: If Itam 27 le marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving J. Hanback 2 Margaret Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Eicherson 1113 Collindale Ave., Mount Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If it eny Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moser Crematory Feb. 9, 2006 Warrenton, VA 22. Name and Address of Facility Moser Funeral Home, Inc. 21. Signature of Funeral Service Licenses 233 Broadview Avenue, Warrenton, VA an 20186 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of d-aih?

1 XYes 2 □ No 1XYes 2□No Be director, 25. Was case referred to medical 26. Place of Death [Check only one] examiner? Hospital: 1 | Inpatient Other: 1 X Yes 2 □ No ၉ 2 ☐ EB/Outpatient 3 DOA Scene this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Aftert Certification: 28d. Describe how injury occurred Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 1 Director: A od in by the f investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours efter To the Funaral Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Submedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 OCME February 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7 2006

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		= State Registrar		Jerti	ficate of L	Jeath		Reg. I	No.		
v		Decedent's Name (First, Middle, Last)					2. Dai	e of Death	Day	Year	3. Time of Death
Physi /Med		WENDELL	HUFFIN					BRUARY		2006	2:00 P M
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Funera	1	Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Dat	e of Birth onth, Day, Ye	ar)	9. Birtho	place (State or Foreign
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irylar show	_	10a. State 10b. County	10c. City, Town	or Loca	tion						1X Yes 2 □ No
e Ma	용	DC	WASHIN	GT01	N,DC						
ih th or 26	Director	10e. Street and Number			10f. Zip Code			10g.	Citizen of	What Cour	ntry?
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dear dea	Funeral	Amec	ecedent Ever in U.S. Forces?	13. Wa If Y	as Decedent of His es, specify Cubar	spanic Origir n, Mexican, f	n? (Specify Ye Puerto Rican,	s or No- etc.)		ce - Americ ck, White,	
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and and m 27 her tr		DOROTHY HUFFIN/MOTHE	R 91		710	1 N.W.	Date			- City or Te	
Definition of permit. Pages 1 am Department of Healimportant: if Item 2 any Injury or other		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal fr	om State cemetery,	, crema	tory or other place						
Pa men tant:		4 Donation 5 Other (Specify)	GLENWO	7	CEMETERY		/7/2006	_		GTON,	
permit. Pages Department of Important: If III	ġ	21. Signature of Funeral Service Licensee			Name and Addres						AL HOME
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ath cer tendin		23b. Was decedent pregnant 23c. if yes	outcome of pregnancy ve birth 2 Petal death	3□E	ctopic pregnancy					ate of deliv Ionth	ery Day Year
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The I	E						11	performed Yes 2		death? 1 ☐ Yes	2 ₺ №
VII THE Sicien: The law scertificate has birector, page 2 s	a)	25. Was case referred to medical				26. Place o	of Death (Che				
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g Ph g Ph er th eral	L	27. Manner of Death 28a. D	ate of Injury Month, Day Year) 28b. Ti	ime of	28c. Injury Work			escribe how i			
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To the within To the comple	M		LAULA ALL		29c. License						Day, Year)
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0 14	1	30. Name and address of person who completed	cause of death (Item 23a) (1	Туре, Р	rint)						
KU		MUSA MOMOHA	D 8700	CE	NTRAL	_ AV	430	1, LA	NDa	16R 1	MD 20785
and a fi	State		2. Registrar's Signature		_						

State Registrar

			For State Registrar	tate of Maryland / Depa Cei	artment of Health ar rtificate of Death		ene 006	04822
	1 1 1 N		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		MARTIN LUTHER HO	OFFMAN		January	31, 2006	8:10 p M
	Examir		4a. Facility Name (If not institution, give stree	et and number)	4b. City, Town, or Location of	Death	4c. County of Deat	
		新之。	9000 Briarcroft Lar	ne, #345	Laurel		Prince Ge	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Day,	rear) Co	hplace (State or Foreign puntry)
A.	Director		Usual Residence of Decedent	72 Yrs.		Nov. 16,	1933 Was	hington, DC
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary Fied	to	Maryland Prince Ge	eorge's Laurel				1X Yes 2 □ No
	r 288	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	ountry?
	h with		9000 Briarcroft Lan	ne, #345	20708		USA	
	deaf	Funerai	11. Marital Status 12. V	Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	14. Race - Ame	
9	or ite		1 Never Married 2 Married 1	1 X Yes 2 No 1954+	1 ☐ Yes 2X No Specify:	deno moan, etc.)	Black, White	White
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21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be nutified at	Completed	15. Decedent's Educatio (Specify only highest grade cor	mpleted) (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)		6b. Kind of Business/	Industry
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	alth a		Michael Edwin Hoffm	nan - Son 1321	6 Cherry Bark	Circle, Rive	rview. FL	33569
Sre		1	20a. Method of Disposition 1 Burial 2 Cremation 3 □ Remo	20b. Place of Dispo			oc. Location - City or	
Ë	Page: nent of ant: If i		4 □ Donation 5 □ Other (Specify)	Maryland	Veterans 2	2/6/2006 C	rownsville	e, Maryland
Baltimore,	permit. Page Department of important: If eny injury or once.		21. Signature of Fundral Service Licens		2. Name and Address of Facility 739 Baltimore A		_	
	V T		23a. Part1. Enter the disease, or complication shock or heart failure. List only one can	ons that caused the death. Do not ent				Approximate Interval Between
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	xecuted and Il-transit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					years
,09	be executed sician and burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of): Hyperlipidemia Due to (or as a consequence of):				years
68760,	ificate be executed g physician and as the burial-transit	dical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					years
9	h certificate be executed ending physician and r use as the burial-transit	dical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23c. I	Hyperlipi demia Due to (or as a consequence of): If yes, outcome of pregnancy			23d. Date of del	
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P.O. Box 6	the Hospital or Attending Physician: The law requires that the death certificate hours after death. the Funeral Director; After this certificate has been signed by the attending npietely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown uting to death but not resulting in the u Lar	26. Place of the state of the s	24a. Was an autopsy perform 1 Yes 2 of Death (Check only one ting Home 5 Resider 28d. Describe how 28f. Location (Stractity or Town, place, and due to the cau occurred at the time, date 29	Month Coco use contribute to	Day Year the cause of death? obably 4 Unknown utopsy findings available completion of cause of 2 No cify) ural Route Number, is stated, to the cause(s) h, Day, Year)
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P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown uting to death but not resulting in the u Lar discrete ital: 1 Inpatient 2 ER/Outpatier isa. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) an: To the best of my knowledge, death On the basis of examination and/or in and manner stated. Hum M eted cause of death (Item 23a) (Type, D Nowth Grass	26. Place of the different and vestigation, in my opinion, death print) 27. Place of the different and the time, date and vestigation, in my opinion, death print)	24a. Was an autopsy perform 1 Yes 2 2 3 1 Death (Check only one sing Home 5 Resider 28d. Describe how 28f. Location (Stra City or Town, place, and due to the car occurred at the time, date	Month 2 No 3 Property of the stand Number of Russes and manner as e and place, and due to Date signed (Month)	Day Year the cause of death? obably 4 Unknown utopsy findings available completion of cause of 2 No cify) ural Route Number, is stated, to the cause(s) h, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 1 15 11 823

		•	For State Registrar		y (Cen	ificate	of L	Death		Re	g. No.) 0	04020
			1. Decedent's Name (First, Middle, L	.ast)							2. Date of Death Month		Year	3. Time of Death
	Physici /Medio		JAMES LINWOOD HA	RRIS							JANUARY	31, 2	2006	3:55P M
<i>y</i>	Examin		4a. Facility Name (If not institution, g				4b. City, T						y of Death	
			HOLY CROSS HOSPI						ER S			MON	TGOME	
	Funeral Director			XX M 2□ F	ge (In yrs. last bir 71	thday)_ Yrs.	If Under 1 Months	Days	If Under Hours	Min,	8. Date of Birth (Month, Day, JUNE 16,			place (State or Foreign ntry) TH CAROLINA
	and and		10a. State 10b. County		10c. City, Tow	n or Loc	ation						1	0d. Inside City Limits
	Ba-f eho	ctor	MARYLAND PRINCE	GEORGES	UPPER	MARLBORO						XXYes 2 □ No		
	or 2	Directo	10e. Street and Number								g. Citizen of What Country?			
	23a	ra	7819 LOCRIS DRIV			20772 13. Was Decedent of Hispanic Origin? (Specify Yes or No-					UNITED STATES 14. Race - American Indian,			
36	n 72 hours after deeth with the Maryland "natural", or Iteme 23a or 28a-f ehow sulcal Exandrar must be notified at	by Funeral	11. Marital Status 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes XX If Yes, Give Year or Dates:		tf	Yes, speci	fy Cuba	spanic On n, Mexicar Specify:	n, Puerto I	Rican, etc.)	Bla	ack, White, ify: BLAC	etc.
3	hour	pa	15. Decedent's		16a	Decede	ent's Usual	Occupa	ation		1	6b. Kind of I	Business/In	dustry
Ċ	in 72 n "nat	Completed	(Specify only highest of	grade completed)		(Give k	ind of work O NOT use	done d	luring mos	t of workii	ng	05. 14110 011	D43111032111	daday
212	s within pene. r then the Mex	ШО	Elementary/Secondary (0-12)	College (1-4or 1 YR.		HIE	FOF	MICE	ROGRA	PHICS	3 1	DEPT.	OF CC	MMERCE
פ	be filed tai Hygi d other event, I	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle, M	aiden Surna	me)	
<u>a</u>	uid be Aentai rkad riic ev	To E	ERNEST CLAUDE HA	RRIS					RUT	H THO	OMPSON			
Maryland 21215-0036	ss 1 and 2 should to Health and Ment item 27 ie markas rother traumatic e	0 1	19a. Informant's Name/Relationship								l Route Number,			
	and ealth m 27		CONSTANCE G. HAR	RIS / WIFE			LOCRI				PER MARL			
ore			20a. Method of Disposition XiX Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of cemeter	f Dispos ry, crem	ition (Nam atory or oth	e of her plac	9)	D	ate 2	Oc. Location	- City or To	own, State
Ē	Fag fment tant: jury		4 □ Donation 5 □ Other (Spec	city)	MARYLA	1							ENHAM	
Baltimore,	permit. Page Department importent: if any injury o		21. Signature of Funeral Service Lig	My cur	Ill		Name and MARSH 4308				HOME O	F MARY	LAND,	INC.
			23a. Part1. Enjer the disease, or co shock, or heart failure. List on	mplications that cause by one cause on each l	d the death. Do i	not ente	r the mode	of dyin	g, such as	cardiac o				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		RENAL FA									Onset and Death 1 WEEK
	/Medical Examiner		resulting in death)	-	a consequence									
9	Examiner		Sequentially list conditions,	V.	ATIC ESP		EAL C	ARCI	NOMA					3 WEEKS
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):								
	and i-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):								
o e	icate be executed physicien and s the burial-transit					,-								
68760	licate phys s the	Medical		d.										
	death certificate be executed e attending physicien and of for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. D	ate of delive	ery
ô R	death ce a attendii d for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a	2 ∏Fetal death t time of death		Ectopic pre Other <i>(spe</i>						lonth	Day Year
O.	by the de	hys	9 □ Unknown	9□ Unknown										
2	The law requires thet the ide has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	contributing to death t	out not resulting in	n the un	derlying ca	use give	en in Part I		23e. Did toba	acco use co	ntribute to t	he cause of death?
Vital Records,	w require been sig should b	be									1 Tes	2 □ No	3 Prot	pably XXIUnknown
ပ္က	awre as be 2 sho	plet									24a. Was an autopsy	24b	. Were auto	opsy findings available mpletion of cause of
ř	The i	Completed									perform	ed?	death?	
IIa	ician: certific rector,	Be (25. Was case referred to medical examiner?						26. Place	e of Death	(Check only one			
	hysic this ce al dire	2	1 ☐ Yes 💥 X No	Hospital: XX Inpati		tpatient			4 🗀 190	rsing Hor	ne 5 Resider	nce 6 🗆 O	ther (Specil	(م)
בַ	Attending Physician: r death. actor: After this certific by the funeral director,	ë.	27. Manner of Death XXNatural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. 1	Time of Injury		C. Injury Work			28d. Describe how	v injury occu	urred	
<u>s</u>	tendi death. tor: A	cati	2 Accident Investigat 3 Suicide 6 Could not	he			М		Yes 2					
Division of	in the call	Certification:	4 Homicide determine	200. Flace of in	jury - At home, fa tc. <i>(Specify)</i>	arm, stre	et, factory,	office		2	28f. Location (Stre City or Town,		ber or Run	al Route Number,
	Hospital	edical C	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my knowledge	e, death	occurred a	it the tim	ie, date ar	nd place, a	and due to the car	use(s) and n	nanner as s	stated, the cause(s)
	vithin 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner st	ated.		290	License	number		90	d. Date sign	ed (Month	Day, Year)
	7 3 F 8		255. digitature and title of certifier	1 1			230.		525	502		21	1/0	6
7	1			1		_		V	04.	, – 3	,	- 1	10	
R	(6)		30. Name and address of person SHAILESH SHETH,	_	death (Item 23a)			LEN	RD.	STLV	/ER SPRI	NG. MI	2091	.0
	Sta	te	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature									
	Registi		PEB 0 3 20	28	, K	from	1							
DH	MH 17 Pay 1/2	001	1 2 5 5 6								100	2977247	nasali n	7. pl

siciar edica mine		1. Decedent's Name (First, Middle, L.	State of Ma Lem 29d per				2. Date of Deat Month	h Day	Year 3. Time o	
mine	al -	JANET W. HEATH As Facility Name (If not institution, gi	ive street and number)		4b. City, Town, or	Logation of Dog	JANUARY	31, 200) P ^M
	r	5001 BRIDGEPOIN			CHESTER			,	N ANNE'S	
ral	5	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)		If Under 24 Hr			Birthplace (State Country)	or Foreign
r		056-30-7342	1□M 2 X F	72 Yrs.	Monato Bays	110010	JAN. 23		NY	
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside C	City Limits
4	tor	MD QUEEN A	ANNE'S	CHESTER					1 🗀 Yes	s 2 X No
-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?	
		5001 BRIDGEPOIN	TE DRIVE	una in 11 C 12	21619	inneria Origina (Sanaitu Van as Na	USA	- American Indian.	
by Funeral		11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Pue	rto Rican, etc.)		K, White, etc.	
	Completed	15. Decedent's E	Education		dent's Usual Occupa		orking	16b. Kind of Bus	siness/Industry	
1	n Pie	(Specify only highest games) Elementary/Secondary (0-12) 12	College (1-4or 54	· life.	DO NOT use retired))	orking	OLDY H	o) ET	
		1 Z 17. Father's Name (First, Middle, Las	et)	HOMEM	IAKER	19 Mothor's Nr	ame (First, Middle, M	OWN H		
c	m	RODMAN KIMMINS	s <i>t)</i>				DURER	vialuen Suniame	=/	
F	္	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street	and Number or F	Rural Route Number	, City or Town, S	State, Zip Code)	
	_	RAYMOND P. HEATH	(HUSBAND)	approximate and	BRIDGEPOI	NTE DRI	VE CHEST	ER, MD	21619	
	2	20a. Method of Disposition 1 XBurial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	θ)	Date	20c. Location - (City or Town, State	
		*4 □Donation 5 □ Other (Spec	oify)		T CEMETER		/2006 A	ANNAPOLI	IS, MD	
		21. Signal Te Funeral Service Lice	- HEM		06 SHAMRO	ELFENBE CK ROAD	, CHESTER	, MD 2.	RAL HOME, 1619	P.A.
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused ly one cause on each line	the death. Do not ent a.			ac or respiratory arre	est,	Approxima Interval Be Onset and	tween
		Immediate Cause (Final disease or condition resulting in death)	d	idder 1	(ancer				thre	e
			Due to (or as a	consequence of):					70	945
100	Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):						
1	Ē	that initiated events resulting in death) Last	C							
	dical E		Due to (or as a	consequence of):						
:	Jean -		U .							
den										
A 18 18 A	a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	□Ectopic pregnancy				of delivery	Year
2	ysıcıar			Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	,	Year
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#20bperFH2/13/06, EMW., McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARJORIE Ε. HERSBERGER 2006 1:25 A M February /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Days 1 ☐ M 2 🔀 F 84 220-50-6765 Vrs Feb. 16,1921 Canada Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Heatth and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other treumatic event. If a Medical Evaninar must be notified at injury or other treumatic event. If a Medical Evaninar must be notified at e. 1 Yes 2 No MD Rockville Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Canada 20850 14212 Travilah Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Beatrice Stephens John Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19714 Framingham Drive Gaithersburg, Md. 20879 Lynne Barrack (Daughter) Date 13 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Feb. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Md. Parklawn Mem. Park 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Zes 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Senile Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I are leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Box 22A) + 10k per V Terreny / BAIW 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð peq 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funerel Direct completely filled in by filled in by 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 1, 2006 D42452 Whe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, Md.20850 Dr. Chitra Rajagopal M.D. 31. Date filed (Month, Day, Year) . Begistrar's Signature State 0 6 2006 Registrar

			1 - For State Registrar		State of	Marylan	nd / Depa	artmen rtificat	t of H e of L	lealth a Death	and M	Mental Hy	/giene) (16	04826
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	/Medi		Russell		Edwar		Han	mers]				Febru	ary 3	2006	
	Examir	ner	4a. Facility Name (If n							Location	of Death	b .		nty of Death	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra <u>once</u> .		20a. Method of Dispos 1 X Burial 2 □		□Removal from St	ate	Place of Dispo cemetery, crea	natory or o	ther place	·		Date	20c. Location	n - City or T	Town, State
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× 1	Physician /Medical		shock, or heart f Immediate Cause (Fir disease or condition resulting in death)		a		CARDIN								Interval Between Onset and Death
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	uted I Insit	Examiner	Sequentially list condi if any, leading to immi cause. Enter Underly Cause (Disease or inju-	ing ury	540 10 (61	23 2 00113641	denos ory.								
Ć.	icate be executed physicien end s the burial-transit	Еха	that initiated events resulting in death) Las		c. Due to (or	as a consequ	uence of):								
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Вох	The law requires that the death certificate be executed ale has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 months and 12 months are	onths?		me of pregna h 2 Fetal it at time of de	I déath 3□	Ectopic pro						ate of delive	very Day Year
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Division	tel or Attendir s after death. el Director: Al ed in by the fu	Certification:	4 Homicide	determine	building	Injury - At ho , etc. <i>(Specify</i>	ome, iarm, str /)	eet, ractory	, office			City or To	Street and Nun wn, State)	nder or Hur	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the tuneral director.		29a. Certifier 1	Certifying	Physician: To the be	est of my know	wledge, death	occurred :	at the tim	e, date an	d place,	and due to the	cause(s) and r	nanner as	stated.
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14	1-3		30. Name and address	s of person wh	to completed cause (or death (Item	23a) (Type,	Print)	9	1.4	7	ne d	2/74	>	
	Sta	te	31. Date filed (Month.	Day, Year)	32. Reg	istrar's Signat	ture	9.170		- 1 1	1:	1113	114	-	-
	Registr	ar	F	FR 0.4	2006	28444	1. A.	and the	p						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Month Year **Physician** Dorothy Russell HETZER February 3, 2006 4:50 p.m. /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Death **Examiner** College Manor Lutherville Baltimore 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F 88 Yrs. Director 215-26-1941 Aug. 22, 1917 Mary Land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health end Mental Hygiene. Important: if items 23a or 28e-f ahow any Injury or other treumatic event, the Medical Examiner must be notified at once. 2008. 1 XYes 2 □ No Maryland Washington Directo Hagerstown 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21740 106 Cypress Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after onent of Health end Mental Hygiene. Int: If Item 27 Ia marked other than "netural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white Baltimore, Maryland 21215-002(þ Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hospital nurse 12 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Murray Mary R. Roney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Suzanne Hetzer - daughter 901 Emerson Ave., Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2/8/06 Hagerstown, Maryland 21. Signeture of Funeral-Service Licensee 22. Name and Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical obstratue long disease Examiner Due to (or es e consequence of) Examiner ettending physician and for use es the buriel-trensit or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? brillatron 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred ASSTD. LIVING 5 ☐ Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / To the Hospital or Atter within 24 hours after ded To the Funeral Director completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024732

ou weine MO

32. Registrar's Signeture

21 West Rd

State

DHMH 16 Rev 6/95

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		State of	Marylar	nd / Depa	artmen rtificate			d Men		giene Reg. No:	06	04828	
	Physicia	an.	1. Decedent's Name (i	First, Middle, Last))							Date of De	ath Day	Year	3. Time of Death	
	/Medic			WESLEY H				1				02	15 2	006	0211 M	
	Examin	er	4a. Facility Name (If no	1		ber)	Las	4b. City,	Town, or	Location of De	eath			ty of Death	~	
			5. Social Security Num	(C) 8N 81 6. Ser	11/11/10/	CPM1	. last birthday)	If Under	1 Year	If Under 24 H	drs lor	Date of Birt		comi		_
	Funeral Director		221-16-38	178	ÎM 2□F	81	Yrs.	Months	Days		fin. (Month, Da	y, Year)	Cou	* '	1
			Usual Residence of De					<u> </u>			- 00	0 29	1724	SHO	VELL, MD	_
	show	L.	10a. State	0b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits	
0	the Mg	Director	DELAWARE	SUSSEX		DA	GSBORO								1 X Yes 2 No	
80	s after death with the Maryland , or theme 23a or 28a-f show reminer must be notified at	급	10e. Street and Number		OAD			10f. Zip		_			10g. Citizen o	f What Cou	ntry?	
3	e 23g	Funeral			OAD	tost Ever is t	10 12		1993		1/Casait.	VN-		ED ST		
	ter dea	Ë	11. Marital Status 1 ☐ Never Married		12. Was Deced Armed Ford 1 ☐ Yes	ces?	J.S. 13.	If Yes, spec	rfy Cubar	spanic Origin? n, Mexican, Pu	uerto Rica	n, etc.)	14. R	ace - Ameri ack, White,		
036	urs aft	þ	3 Widowed 4 [If Yes, Give Year or Da			1 ☐ Yes 2	2 X No	Specify:			Spec	ify: BL	ACK	
221-/2	filed within 72 hours after Hygiene. ther then "natural", or the ent, the Medical Examina	Completed		5. Decedent's Edu only highest grade			16a. Dece	dent's Usua	l Occupa	tion uring most of	working		16b. Kind of	Business/Ir	ndustry	-
2	ithin	Jq.	Elementary/Seconda		College (1-	4or 5+)	life.	DO NOT us	e retired)		working					
2	be filed withing tall Hygiene. Ind other then event, the M		12 17. Father's Name (Fir	na Adiddle I ness			TRU	CK DI	RIVE					KING		_
anc anc	S d a B	Be		EDWARD	HALL								Maiden Suma	ame)		
Sohn aryland	d 2 should be filed with and Mental Hygiene 7 is marked other the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event.	ပ္	19a. Informant's Name				19h Maili	ng Address	(Street a		STER		TON ar, City or Tow	n State Zi	Codel	
. ≥	and 2 sealth and 2 sealth and 27 is		MARY M.		IFE)		305	-		ROAD;					Cope)	
, ē	~ 포 들 들		20a. Method of Dispos		LT 11/		Place of Dispo	sition (Nam	e of		Date	JAVAG	20c. Location	19939 · City or To	own, State	
其品	~ = 6		1 X Burial 2 □ 0 4 □ Donation 5		temoval from S	late 1	cemetery, crei			.	-11-2	006	BISHO	PVTIT	F MD	
	permit. Pag Department Important: eny injury once.		21. Signature of Funer	Service Licens	99 0.	,	22	2. Name and	d Address	of Facility		-	DIBIIO	t A TITI	E, MD	
Δ.	8 8 E 8 B		10/1/2	ungt	07/16			ATSON ILLSB(ERAL HO	ME					
			23a. Part1. Enter the shock, or heart fa	disease, or compli ailure. List only or	ications that ca	used the dea	th. Do not ent	ter the mode	of dying	, such as card	diac or res	piratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Findisease or condition	nal	Có	ovon	WY	Avt	eru	DIS	eas	e			Onset and Death	
	/Medical Examiner		resulting in death)		Due to (o	r as a consec	quence of)		1						/	
		-	Sequentially list condit	tions, b		r as a consec	quanca of):								·	_
	red nsit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlyi Cause (Disease or injuries)	ng	500 10 10	as a consec	quence or).									
ć.	be executed sicien and burial-transit	Exal	that initiated events resulting in death) Las		Due to (o	r as a consec	quence of):									-
8760,	ate be hysicie the bur	dlcal			1											
68	rtifical ng ph as th	0														_
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pr	egnam	3c. If yes, outco	ome of pregn th 2 Peta	ancy al death 3	Ectopic pre	onancy					ate of deliv	*	
E	it the dea by the at tached fo	Physician/M	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown			nt at time of o		Other (spe					\ \ \	lonth	Day Year	
P.O.	that the	된	Part II. Other significa	nt conditions con	stributing to doc	th but not so	culting in the c			in Dawl		naa Did ta				-
Division of Vital Records,	8 50	1 by	rattii. Ottor signinoa	TH CONGRESS CON	ithouling to dea	tin but not res	salang in the a	ndenying ca	iuse giver	nın Part I.			es 2□No	a Drot	he cause of death?	
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ě	The lav	Completed									- '	24a. Was autop perfoi	sy	. Were auto prior to co death?	ppsy findings available impletion of cause of	
<u> </u>	ician: Th certificate rector. pag	ပ္	25. Was case referred	to medical								I ☐ Yes	2 🗷 No		2 No	_
=	ysician: is certific director.	To Be	examiner?	- 4	lospital:	patient 2] ER/Outpatier	nt 3 DO	Other	26. Place of C						_
o	g Phys er this eral di		27. Manner of Death		28a. Date of	Injury	28b. Time of		Bc. Injury				ence 6 0		ÿ)	
Ö	death. ctor: After y the funer	atlo	1 ☑Natural 5 2 ☐ Accident	5 ☐ Pending investigation	(MONIN,	, Day Year)	Injury	м		es 2 No						
	r Atte	tt tt	3 ☐ Suicide 6	Could not be determined	28e. Place o	f Injury - At h	ome, farm, str	eet, factory,	office		28f. L	ocation (S	Street and Num	ber or Rura	al Route Number,	
Ö	ftal on	Certification;														
	Hosp 4 hou Fune tely fil	edical	29a. Certifier 19 (Check only 20 one)	Certifying Phys Medical Examir	sicien: To the bas ner: On the bas and manne	is of examina	owledge, death ation and/or in	h occurred a vestigation,	it the time in my opi	e, date and pla nion, death oc	ace, and d ccurred at	lue to the o	cause(s) and n date and place	nanner as s , and due to	tated. the cause(s)	
	within 2 To the comple	Me	29b. Signature and title	o-of certifier				29c.	License				29d. Date sign	ed (Month,	Day, Year)	-
	/B			4	5				D	3678	3		02	105	106	
_	63		30. Name and address	of person who co	mpleted cause	of death (Iter	m 23a) (Type,	Print)							L	_
	10		octtr	ey E-	ther	1000	mo-	PRI	he,	SALT	SBU	124,1	MD-	218	04	
	Stat Registra		31. Date filed (Month, I	Day, Vd ar) FR () 7 20	32. Re	gistrar's Signa	ature	P 100	,			(

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate o		ind Menta	l Hygier	100	6	04829
			1. Decedent's Name (First, Middle, Las	it)					e of Death		\/-	3. Time of Death
	Physici /Media		Georgieanna Ha	milton				Febr		Day 1, 200	Year 6	11:27 PM
	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of			4c. County	of Death	1
1			7810 Tall Oak Pl	ace		Charlo	tte Hal	1		Cha	rles	
	Funeral		Social Security Number 6. S	-	(In yrs. last birthday)	If Under 1 Ye Months Da		Min. 8. Date	e of Birth	ar)	9. Birthp	lace (State or Foreign
	Director		5/8-30-8120	□M 20X F	87 Yrs.		,,,	Jul	y 10	1918	Mar	ýland
	and w	}	Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation					1	0d. Inside City Limits
	farylan ehow	5		_	••		,					1 ☐ Yes 2 🕅 No
	28a-1	ect	Maryland Charle 10e, Street and Number	5	Charlo	tte Hal			100	Citizen of W	hat Cour	atru?
	with	ā	7810 Tall Oak Pla	20			0622		109.	US		Ri y :
	after death with the Maryland or Iteme 23s or 28s-f ehow other name be notified at	Funeral Director	11. Marital Status	12. Was Decedent B	ver in U.S. 13			in? (Specify Ye	s or No-	_		can Indian.
10		필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 N	0	If Yes, specify C	uban, Mexican,	in? (Specify Ye , Puerto Rican, e	etc.)		, White,	
936		þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X ☐ I	No Specify:			Specify:	Wh	ite
21215-0036	naturel', "naturel',	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	cupation	and a constraint of the second	16b	. Kind of Bu	siness/In	dustry
218		pie	(Specify only highest gra	College (1-4or 5	life.	kind of work do DO NOT use re	ine during most tired)	or working				
21	e filed within al Hygiene. I other then "vent, the Me	No.	8		Line	Proces	sor			Meat	Pac	king
pu	be filed withintal Hygiene. Id other than	Be (17. Father's Name (First, Middle, Last)					r's Name (First,)	
yla	Ment Ment Mrkec	ဂ္ဂ	George William St	amp			Mary	Magdal	ene Br	ady		
Maryland	s 1 and 2 should be f Health and Mental Item 27 is marked other traumatic ev	- 9	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Str	eet and Number	r or Rural Route	Number, Cit	y or Town, S	State, Zip	Code)
	of Health of Hem 27 is		George T. Hamilto	n, Jr S				e, Wald				
ore	of H of H if Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		matory`or other i	place)	Date	20c.	Location - (City or To	own, State
Ë	Pag ment ant: ury		4 □ Donation 5 □ Other (Specify		Trinity M	lemorial	Gdns 2	-6-2006	Wal	dorf,	MD	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Licen	™ M0124	0	2. Name and Ad Huntt F		P. Home Wa	-			5 Old Wash
	Physician /Medical Examiner	ier	23a. Part1. Enter the disease, or com, shock, or heer failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to (or as a	the death. Do not enile. consequence of):	ter the mode of o	dying, such as c	cardiac or respir	atory arrest,			Approximate Interval Between Onset and Death
,8760,	cate be executed physicien and the burial-transit	dicai Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):							
P.O. Box 6	n requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death 3	Ectopic pregna Other (specify,				23d. Date Mon		ery Day Year
	that ned b	y P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause	given in Part I.	236	e. Did tobacc	o use contri	bute to th	ne cause of death?
Records,	equires sen sign could be	D D							1 🗌 Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
00	w red bee	iete						24:	a. Was an	24h W	ere auto	psy findings available
Re	The law ete has page 2 a	Ę							autopsy performeg/	? pr	or to con	impletion of cause of
Vital	ician: Th certificete rector, pag	ပိ	25. Was case referred to medical	_					Yes 2/2	No 1	Yes	2 No
5		80	examiner?	Hospital:	nt 2 ER/Outpatier	nt 3 DOA	Other	of Death <i>Check</i> sing Home 5	/	2 DO++	. /С/	1
o	Physer this eral di	٦: <u>٦</u>	27. Manner of Ceath	28a. Date of Injur	y 28b. Time o		njury at Work?		scribe how in			7)
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		ry - At home, farm, str	M 1	Yes 2 N	28f. Loc	ation (Street or Town, St		r or Rura	l Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical Ce	29a. Certifier (Check only one)	ysician: To the best of liner: On the basis of and manner sta	examination and/or in	h occurred at the vestigation, in m	e time, date and ny opinion, deatl	d place, and due h occurred at the	to the cause itime, date a	e(s) and man	ner as si	ated. o the cause(s)
	To th within To th	Ž	29b. Signature and title of certifier	7/		29c. Lice	ense number		29d.	Date signed	(Month,	Day, Year)
			Hames	Harren	e.	n	10 524	919		2/2/	00	
1	0 2 5 1		30. Name and a dress of person who	concleted cause of dy	th (Item 23a) (Type,	Print)				11	0 10	
	BBB		James Harring, MI), 102 Cen	tennial St	., #102	, La Pl	ata, MD	20646			
	Sta	te	31. Date filed (Month, Day, Year)	32. Ragistra	r's Signature	/ ,						

		4	1 - For State Registrer	ate of Maryland	/ Department Certificate		lental Hygie Reg.	<u> </u>	04830
N. A.	in 18 year	272	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Georgia	Ann	Hedrick		\bigcirc	3 00	4:15 A.M.
)	Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, To	own, or Location of Death		4c. County of Death	
7			SACRED MEART MO	spital	Cun	nberLand		AlleGA	NV
15,	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. ias		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
\$ 1.	Director		213-40-4165	2KJ F 65	Yrs.	Jays Tiours Will.	01/12/194		land
	p ,		Usual Residence of Decedent	100 City 1	Town or Location				10d. Inside City Limits
	aryla	_	10a. State 10b. County	Toc. City,	rown or Location				1 □Yes 2 □ No
	8a-f	ctc	MD Allegany		<u>Cumberlan</u>				73
	or 2	Director	10e. Street and Number		10f. Zip C	ode	10g.	. Citizen of What Cou	intry?
	ath v		107 Willmont A			21502		USA	
	ar de tamé	Funerai	A	as Decedent Ever in U.S. med Forces?	13. Was Deceder	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	lf If	∐Yes 2⊠No Yes, Give	1 ☐ Yes 2 ☐	No Specify:		Specify:	
21215-0036	d within 72 hours atter death with the Maryland Jiene. I then "natural", or Itame 23a or 28a-f ahow Ita Medical Eval. I set must be codified at			ear or Dates:	16a. Decedent's Usual (Occupation	161	b. Kind of Business/li	hite
15	"na"	Completed	15. Decedent's Education (Specify only highest grade con		(Give kind of work life. DO NOT use	done during most of work		b. Killa of Basillessyll	industry
12	within ene. than	щ	Elementary/Secondary (0-12) C	olfege (1-4or 5+)		maker		Home	
	e fited value of Hygie other i	ပိ	17. Father's Name (First, Middle, Last)		nome		e (First, Middle, Mai		
an	d be antal	00	Eli	Roksandich	1	Wanett	a I	Doris	Bobo
<u></u>	should by	으	19a. Informant's Name/Relationship (Type, F			Street and Number or Rura			
Maryland	id 2 sho ith and 27 is mu traum		Vicki L. Layton / da			ia Street, C			
a)	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 is marked otha other traumatic avent,		20a. Method of Disposition	20b. Plac	ce of Disposition (Name	of	Collins I. College	c. Location - City or T	
altimore,	Pages nent of I ant: If Its arry or o		1 X Burial 2 Cremation 3 Remov	al from State	netery, crematory or other		12006	Cumbonlon	A MD
Ħ	artme ortan injury	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	nill	crest Mem.	Park 01/26 Address of Facility Ad		Cumberlan	
Ba	permit. Pages Department of Important: If I any injury or once.		VILE DO	. ()		catur Street		2	21502
Same 1			23a. Part1. Enter the disease, or complication	ns that caused the death.					Approximate
			shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.		, -			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Melastati		- unkno	w frim.	ary	2 month
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		2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):				
	nsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events						
	be executed sicien and burial-transit	xai	resulting in death) Last	Due to (or as a conseque	nce of):				
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Вох	death certific e attending p ad for use as i	N N		yes, outcome of pregnanc				23d. Date of delin	very
ă	d for	ciai	in the past 12 months?	□Live birth 2□Fetal de □Pregnant at time of dea				Month	Day Year
o.	that the de led by the a detached t	Physician/M	9 Unknown 9	Unknown					
σ.	es that igned b	by P	Part II. Other significant conditions contribu	ting to death but not resulti	ing in the underlying cau	ise given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds	n sign	d bé	Chronic obstru	ctive pu	Immoman) duseus	1 Pres	2 No 3 Pro	bbably 4 🗆 Unknown
Vital Records,	The law requires ate has been sign bage 2 should be	Completed		•			24a. Was an		topsy findings available
Re	The law ate has page 2 :	mc					autopsy performe	d? death?	ompletion of cause of
ā		Ö	25. Was case referred to medical			26 Place of Dogst	1 Yes 2 L	1 ☐ Yes	2 D NO
5	Physician: this certific ral director,	0 B	examiner?	af: 1 Impatient 2 EF	R/Outpatient 3□ DOA	Other		e 6 □Other (Spec	ofu)
ō	Phy ar this aral o	-		a. Date of fnjury 2	8b. Time of 28d	c. Injury at	28d. Describe how		,
Division	Attending ir death. ector: Aftei by the fune	it o	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
/isi	or Attendi after death. Director: A in by the fu	fice	3 ☐ Suicide 6 ☐ Could not be 28	e. Place of Injury - At hom	e, farm, street, factory, o	office		et and Number or Ru	ral Route Number,
á	after Direction of the direction of the	Certification:	4 Homicide	building, etc. (Specify)			City or Town, S	state)	
	Hospital 24 hours a Funeral tely filled		29a. Certifier 1 Certifying Physician	: To the best of my knowle	edge, death occurred at	the time, date and place,	and due to the caus	se(s) and manner as	stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner:	On the basis of examination and manner stated.	n and/or investigation, in	n my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To th withii To th comp	M	29b. Signature and title of certifier	11 11 1	29c. I	License number	29d	. Date signed (Month	i, Day, Year)
	2		Mountemad	27 /1.1)	1	0510207	To	enuan 2	3, 2006
•			30. Name and address of person who comple	ted cause of death (ftem 2	(3a) (Type, Print)				
	nds		Husam Seman	n MO. 9.	00 Seton	DRIVE, C.	umherl	and MI	21502
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re .				
40	Registr	ar	JAN 2 4 2006	Jan .	15 Apole	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #5, 2/7/06, CC, Kent Co. State of Maryland / Department of Health and Mental Hygiene

1- State Registrar

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HUMENIUK ALEKSANDRA **Physician** 2006 6:00 AM 3 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTUWN 101 NORGNEC RD F103 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCTOBER 12,1910 Birthplace (State or Foreign Country)
 POLAND 5. Social Segurity Dymyes 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 X F = 200=32-2075 95 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if fram 27 is marked other than "natural", or flems 23e or "no" any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No KENT CHESTERTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 MORGNEC ROAD F103 21620 POLAND Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Tes 2 No WHITE Specify: Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KYPIRAN LYPNYCHA ESABELLA CHOROWYCZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERA HADAWAY/DAUGHTER 101 MORGNEC ROAD F103, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION 02/04/2006 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER KOAD, CHESTERTOWN, MD 21620 rt1. Enter the diserne, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset_and Death Immediate Cause (Final disease or condition resulting in death) >5 years Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 □ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an Jas autopsy page certificate 20**Z**I No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

tha Hospital or Attanding Physician: within 24 hours a

(3)5 of death (Item 23a) (Type, Print) 122 Speer Rd. Chester town, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Noble Helen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

one

29b. Signature and title of certifier

29c. License number

D0041587

29d. Date signed (Month, Day, Year)

Amend item#4a-b, pen/L,3852 2/28/00 in Black Indelible Ink. Ensure All Copies Are Legible.

-1	-	For Amend item#281		3/18/06 11 ^r Ce	rtificate of L	Death		Reg. Nö		04832
Physicia	n	1. Decedent's Name (First, Middle, Last IFEANYI)	IBETOH			2. Date of De Month Janua	Day	8, 2006	3. Time of Death 2:15 A
/Medica Examine	al er	4a. Facility Name (If not institution, give Doctor's Hospital Prince George's I	street and number)	nter	4b. City, Town, or Lanham - Chever1			4c.	County of Death	
uneral irector		5. Social Security Number 6. Se 579-13-7132		In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		nh 1 ay, Year) mber	986 9. Birth COL 29 WASI	place (State or Foreigntry) HINGTON, DC
notified at		Usual Residence of Decedent 10a. State 10b. County MD PRINCE GI	_	Oc. City, Town or Lo	ocation					10d. Inside City Limit
23a or 28 unithe no	Funeral Director	10e. Street and Number 8106 TRIPLE CROWN	ROAD		10f. Zip Code 20715				izen of What Cou S.A.	intry?
9	à	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hid If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
or than "natural", the Medical Ext	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) IESTIC	lurina most of wo	rking		ind of Business/li	ndustry
d of	To Be Co	17. Father's Name (First, Middle, Last) GORDIAM IBETOI	H				me (First, Middle	, Maiden		
ff item 27 is marke or other traumatic	-	19a. Informant's Name/Relationship (T) CELINE OGBUNIGME			ng Address (Street a					
important: if item 27 is any injury or other trac	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3 3 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cree FAMILY F	natory or other place	2/2	Date 7/2006		SERIA, WE	own, State ST AFRICA
Important: If any injury or once.		21. Signature of Funeral pervice Licens	*	1111	2. Name and Addres				S FUNERA MARYLAND	
hysicie the bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	consequence of	e VI ES					Onset and Death
or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 live birth 2 [4 live pregnant at times 9 live when 2 live week the second sec	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	reny Day Year
eg .	۵	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause give	on in Part J.			/	the cause of death? bably 4 □Unknow
certificete hes been s'ector, page 2 should	Completed						24a. Was auto perfo 1 Yes		prior to co	opsy findings availabl ompletion of cause of 2 No
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£ - 1	Certification; T	27. Manner of Death 1	28a. Date of Injury (Month, Day Y	28b. Time o Injury / 3 U - At home, farm, str (Specify)	M 28c. Injury Work M 1 □ Y		28d. Describe Driver 28f. Location (City or To	how injur	y occurred	Licie (YES. Tal Route Number, Dr. @
Funera etely fille	edicai		sician: To the best of r ner: On the basis of ex and manner stated	camination and/or in			and due to the	cause(s)	and manner as	stated.
0	Me	29b. Signature and title of certifier	102 A	100	29c. License				te signed (Month	
5)			(w) XI		OCME	1		Jan	uary 20,	2000

State of Maryland / Department of Health and Mental Hygiene

				Otato of Mi	ary rarra 7	Certificate	of Dea	ath		Reg. No.	6	ध्वर	13
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Dee	eth	V	3. Time of	Death
	Physici		N	ellie B.	Imhofi	E			Month Jan.	27, 20	Yeer OOG	8:00	P.M.
	/Medic Examin		4e Fecility Name (If not institution, g				4b. Ci	ty, Town, or Lo	cation of Death	4c. County	of Deeth		
-	de		20500 McMull	en Hwg. S	S.W.		Rav	vlings		Allo	eq.		
	Funeral			Sex 7. Ag	e (In yrs. lest b	irthday) If Under 1 Months	1 Year If U	Inder 24 Hrs.	8. Date of Birt (Month, De)			place (State o	r Foreign
	Director		232-62-5875	1□M 2QF	6	Yrs.	Days 110	7010	6-15-			WV	
3	D.	' [Usuel Residence of Decedent									10d. Inside Ci	to Limite
	anylar Bhow	_	10a. Stete 10b. County			wn or Locetion					'	1 ☐ Yes	-
	Sa-f	5	MD Alleg	•	Rawl:								-72
	# 6 #	Director	10e. Street end Number			10f. Zip (Code			10g. Citizen of	Whet Cour	ntry?	
	72 hours after deeth with the Maryland "natural", or frems 23a or 28a-f show edical Examiner must be notified at		20500 McMulle				1557			USA			
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decede If Yes, specif	ent of Hispan ify Cuban, Me	ic Origin? (Spe exican, Puerto	ecity Yes or No- Rican, etc.)	Bla	ce - Americ ck, White,	can Indian, etc.	
20	s afte	by F	1 Never Married 2 Married	If Yes, Give **	No	1 □ Yes 2	No Sp	ecify:		Specif	v: Wh:	ite	
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an	uld be Aentel rked o	To Be	Warren Harr				τ	Kathor	ine De	orlar			
7	d 2 should be filed h end Mentel Hyg 7 is marked othe traumetic event,	F	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address				-	, State, Zip	Code)	
Š			Mary Ann Imho	ff - Dauc	hter '	20500 Mc	·Mulle	en Hwa	SW	Rawl -	inas	MD21	557
ē	f Heal	- 1	20a. Method of Disposition	II - Daug	20b. Place	of Disposition (Name ery, crematory or oth	e of	JII (IVV)	Date	20c. Location	- City or To	own, State	
altimore, Maryland 21215-0020	8 5 = 9		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec					i	. 24 0	C 14			10
	nemit. Pa Departmen Important: Iny Injury		21. Signature of Funeral Service		Phi	los Ceme		Facility		6 West	and the same of the same of	Well interest	D
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			William N.C.	WIRN	the death Do	31 Jo	nes S	St. Pi	edmont	WV 2	26750	O Approximate	Δ
N. Carlot			23a. Part1. Enter the disease, or conshock, or heart failure. List on	y one cause on each li	ne.	Thot enter the mode	or dying, su	on os cardiac c	or respiratory as	1001,	1	Interval Bet Onset and I	ween
ز	Physician /Medical		Immediate Cause (Final	1), /.	D	P	6			3	0 .	
	Examiner		disease or condition resulting in death)	a	10450	USS CON	/shual	son				CV	2
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	nsit	Examiner		ı b	MARIC	peral	los lye	,]	- 4	A
	el-tre	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or as a	consequence of					1	10	
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68760,	rtificete ng phy s es the	edicai	resulting in death) Last		Dueno (or as e	consequence or,					j		
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Вох	v requires that the death ce been signed by the ettendi should be deteched for uss	Physician/	Part II. Other significant conditions	contribution to don't h	ut not reculting	in the underlying ca	use civen in	Parti	23h Did t	obacco use co	ntribute t	o the cause o	of death?
P.O.	the car	hys	raitii. Other significant conditions	A Contributing to death b	ut not resulting	in the underlying ca.	dise given in	raiti.	10	_/		bably 4	
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o	Phys	7: 7	27. Menner of Death	28a. Dete of Inju	ont 2□ER/O ry 28b.		3c. Injury at Work?			now injury occur		(y)	
o	dlng h. Afte	후	1 Netural 5 ☐ Pending 2 ☐ Accident investigati	(Month, De	y Year)	Injury M	Work? 1 ☐ Yes	2□No					
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Division	or A effer Dire	Certification:	4 Homicide	building, et	c. (Specify)				City or Tow	vn, State)			
_	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying F	hysician: To the best of	of my knowledg	e, death occurred e	t the time, da	ite end place.	and due to the	cause(s) end m	anner as s	stated.	
	How Fur	edicai	(Check only 2 Medicat Exa	miner: On the basis of and manner ste	examination e	nd/or investigation, i	in my opinion	n, death occurr	ed et the time,	date and place,	and due to	to the cause(s	.)
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	5		1/	Karithe			1)19	318		Jo	n 30	7200	96
		. 1	30. Name end address of person who	completed onuse of ri	eath (Item 23e)	(Type, Print)	V''						
	nu		N. A. Ranjithan			wn Road,	Cumber	land.	MD 215	02			
y.	Sta	te	31. Date filed (Month Day, Year)		er's Signature	/							
4	Registr	-	JANDIZ	JUD JUD	and with	Sparke							

30C	312			ype or Print in Black in			-	
			FOR	State of Maryland / Dep			4000	04834
			State Registrar	Ce	rtificate of Death	Reg 2. Date of Death	J. No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)			Month	1, 2006	
4	/Medic	ai	MARTHA ANN INSLEY		1 0 T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	February	4c. County of Death	6:30 p. M
J. Carlot	Examin	er	4a. Facility Name (If not institution, give st 231 Eden Street	reet and number)	4b. City, Town, or Location of Death Salisbury		Wicomico	Country
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,		8. Date of Birth		
	Funeral			M 2/2 F 46 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	rear) Cou	olace (State or Foreign ontry) ORD, DE
	Director		222-52-8515 Usual Residence of Decedent	40		03-30-19	J9 III III	ORD, DE
	ylanc		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mar Fel	to	MD WICOMIC	O SALISB	URY			1 ☐ Yes 2\ No
	or 28	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	th wi	ai	231 EDEN STREET		21804		USA	
	dea dea	ner	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
စ္က	or it	by Funerai	1 ☐ Never Married 2 🕅 Married	1 ☐ Yes 2 ᠓No If Yes, Give	1 ☐ Yes 2 🛣 No Specify:		Specify:	
g	nours ural',		3 Widowed 4 Divorced	Year or Dates:		14/		ITE
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an	d be antal	To Be	ALFRED CREED, JR.		PEARL E	POLLARD		
<u>-</u>	and Mental e marked o	ř	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mail	ing Address (Street and Number or Rur		City or Town, State, Zi	o Code)
Š	and 2 sealth ar n 27 le		MICHAEL INSLEY - S	POUSE 231	EDEN STREET, SALISE	BURY, MARY	LAND 21804	
	- T = 5		20a. Method of Disposition	20b. Place of Disp			Dc. Location - City or T	own, State
9	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Y OF DELMARVA 02-0	13-2006 D	FIMAR DET	ΔΜΔΡΕ
Baltimore,	그 된 원 등 .	1	21. Signature of Funeral Service License		2. Name and Address of Facility BOL			
ä	Depariment impo		1 Maso 14		705 EAST MAIN STRE			
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	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	ot Wand of the			
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68	death certifical e ettending phy of for use as th	Med	IF FEMALE:					
Box	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deli-	rery Day Year
<u>.</u>	the elf	Physician/Medi	1 ☐ Yes 2 ☐ No 9	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)	*		,
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Division of Vital Records,	ਛੋਂ ਜ਼ੋ		1X Yes 2 No 27. Manner of Death	1 ☐ fnpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time	ant 3 DOA 4 Nursing He	ome 5 ☐ Resider 28d. Describe hov		My At Scene
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2	or Attendelier death Director:	fica	3 Suicide 6 □ Could not be	28e. Place of Injury - At home, farm, s	treet, factory, office		eet and Number or Ru	
ē	effer Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	re.	City or Town,	State) 23 Eg	In Street
	Hospitei		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my knowledge, dea	ith occurred at the time, date and place,	and due to the car	use(s) and manner as	stated.
	P Ho	Medical	(Check only 2 Medical Examination)	Ier: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To the Hospitel or Atte within 24 hours efter de To the Funeral Directo	×	29b. Signature and title of certifier	1 4	29c. License number		d. Date signed (Month	
	13		Thirden U.	Fit X mus	OCME	Fe	ebruary 2,	2006
	100		30. Name and address of person who co	mpleted gause of death (Item 23a) (Type	Print) 111 Penn Stre	et Balti	more, Mary	land 21201
_	(V)		THEODORE Miking	•				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A 00			

			1 - For State Registrar	State of Mar	ryland		rtment of H		nd Mental Hy	giene Reg. No.	106	04835
	Discouries in the		1. Decedent's Name (First, Middle, Las	t)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Roscoe Jami	son, Jr.					January	~ ~		3.4
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of	Death	4c.	County of Dea	eth
			Holy Cross Hos						Spring			tgomery
	Funeral		5. Social Security Number 6. Se	ex 7.Age(XIM 2□F		st birthday) Yrs.	If Under 1 Year Months Days	If Under 2- Hours	Min. (Month, Da	y, Year)		rthplace (State or Foreign country)
	Director		257-22-4867 Usual Residence of Decedent		85	713.			Mar. 8.	192	0 So	uth Carolina
	land ow		10a. State 10b. County	1	10c. City,	Town or Lo	cation		··-·			10d. Inside City Limits
	Mary -f sh	ţō	DC					VI. ah	in at an			1X Yes 2 □ No
	r 28a	Director	10e. Street and Number				10f. Zip Code	Wash	ington	10g. Citiz	zen of What C	country?
	h witi		2100 - 19th	St., N.W.	#604			20009		IJ	nited	States
	deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	. 13. V	Vas Decedent of H	ispanic Origi	in? (Specify Yes or Ne Puerto Rican, etc.)		4. Race - Am Black, Whi	erican Indian,
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give)		☐ Yes 2♥ No	Specify:	. 40,10 1 110411, 010.7			frican
8	ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:			21				A ₁	merican
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Maclical Examitre must be mailfied at	Completed	15. Decedent's Ed (Specify only highest gra			(Give	ent's Usual Occupa kind of work done o OO NOT use retired	durina most d	of working	16b. Kir	nd of Business	s/Industry
12	withlr ene. then	μ̈	Elementary/Secondary (0-12)	College (1-4or 5+))						D .	
9	e filed all Hygie I other I		6th 17. Father's Name (First, Middle, Last)				Laundry '		Driver 's Name (First, Middle	, Maiden		vate
an	d be ental ked o	To Be	Unkno	wn					(Unkno	15.772)	Royd	
Maryland	2 should be f and Mental I is marked of raumatic eva	 	19a. Informant's Name/Relationship (7			19b. Mailin	g Address (Street a	and Number	or Rural Route Numb			Zip Code)
	1 and 2 Health a tam 27 is		Yolanda McKie/D	aughter		958	4 Muirki	rk Rd.	, #101, La	ure1	, MD	20708
altimore,	toes 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, Ite Maryles Examiner must be calified at		20a. Method of Disposition	D	20b. Pla	ce of Dispos	sition (Name of natory or other place	(e)	Date	20c. Lo	cation - City o	r Town, State
Ĕ	permit. Pages Department of H Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			-		1	/27/2006	В	rentwo	od. MD
alti	permit. Departn Importe eny inju		21. Signature of Funeral Service Licen	são A			. Name and Addres		The state of the s			
<u> </u>	89589		10/m 1.	leval 1	11		4001 Be	enning	Rd., N.E.	Was	h., DC	20019
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compositions, block, or heart failure. List only of the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each line.	tate conseque monia	Cance ence of):		g, such as c	ardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
	ted nsit	nine	Cause (Disease or injury	Septi								
Ć,	sician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a								
8760,	ate be ex hysician a	cal		d								
9	rtifica ng ph as th	0	IE EEN II E					- 591		110		
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal	death 3 □	Ectopic pregnancy Other (specify)			2	23d. Date of de Month	elivery Day Year
σ.	requires that een signed b nould be deta	by Pr	Part II. Other significant conditions of	ontributing to death but	not result	ting in the ur	iderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
of Vital Records,	w require been sig should b	pe pe	Anemia						1 🗆	Yes 2[□No 3□F	Probably 4 Unknown
000	> 0 70	ompleted							24a. Was		24b. Were a	autopsy findings available
R	The te h age								auto perf 1 ☐ Yes	ormed? 24 No	death?	
ita	certifica rector, p	BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check only			
<u>\$</u>	dii dii	10	1 ☐ Yes 2 ☐XNo	Hospital: 1 Anpatient	t 2□E	R/Outpatien	1 3□ DOA Oth	er: 4 🗆 Nurs	sing Home 5 Res	idence (0ther (Sp	ecify)
Division o	ding h. After fune	ertiflcation;	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation		Year) 2	28b. Time of Injury	28c. Injun Worl M 1 □	yat k? Yes 2□N	28d. Describe	how injur	y occurred	
Divis	in Direct	Certifle	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At hom (Specify)	ne, farm, stre	eet, factory, office			(Street an wn, State		Rural Route Number,
	ë <u>-</u>	ledical		ysician: To the best of niner: On the basis of e and manner state	examination							
	To the P within 24 To the P complete	ž	29b. Signature and title of certifier		_	11	29c. Licens	e number		29d. Dat	e signed (Mor	oth, Day, Year)
•			1/av	sun		U	_	D63334	4	F	ebruar	y 1, 2006
1	2)		30. Name an address of person who Haval Saa	d11a, M.D.	1500	Fore	st Glen	Rd., 9	Silver Spr	ing,	MD 209	10
	Sta Regist	•	31. Date filed (Month, Day, Year) FEB 0 6 2000	Registrar	's Signato	fre	w					

		1	For State of Maryland	/ Department of Health and M Certificate of Death	Mental Hygien	- ZUUD HERRA
	Dhysisis		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medica	al -	Sherry Faye Jester		02 04	f 2004 1121 AM
	Examine	er	ta. Facility Name (If not institution, give btreet and number)	4b. City, Town, or Location of Death	4	Wicomico
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Days Mours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director	-	214-66-9161 1 M 20F 65 Usual Residence of Decedent	Yrs.	05-24-1	940 Virginia
	yland now			Town or Location		10d. Inside City Limits
	Ba-fet	ctor		incoteague		1 Yes 2 No
	with the	Dire	6257 Clark Street	101. Zip &de 23336	10g. C	Citizen of What Country?
	ma 23	Jeral	11 Marital Status 12. Was Decedent Ever in U.S.		pecify Yes or No-	14. Race - American Indian,
98	iled within 72 hours after deeth with the Maryland it Hygiene. of Hygiene. returet then "neturet", or itama 23a or 28a-f ehow vent, tra Medical Examinat must be notified at	Completed by Funeral Director	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ② KNo Specify:	Hican, etc.)	Black, White, etc.
ő	turet.	ed b	3 ⊠Widowed 4 □ Divorced Year or Dates:	16a. Decedent's Usual Occupation	16b.	White Kind of Business/Industry
215	thin 72 en "ne Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	0 1
21	n 5		10	Waitress	ne (First, Middle, Maide	ills Gestaurant
and	Q ≒ Z ●	To Be	17. Father's Name (First, Middle, Last) Alooh Justice	Meld	a Daise	
aryl	& E E	ř	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rus	-1	-4
Σ	12 ad	1	Kim Godwin / Daughter	6257 Clark St. Ch	incotcae	
Baltimore, Maryland 21215-0036	90 -		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, crematory or other place)		Location - City or Town, State
ij	permit. Pag Department Important: I any njury o	ŀ	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	SCY (cmetery 21"	7106 (hincoteague, VA
ã	permit. Departinitimports any nit		I amanda C-Botts	Salver Funeral Homo	e 6327 Cl	hurch St. Chincokas
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
6	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ie Shock		minutes
\sim	Examiner		Due to (or as a conseque	2 (1.		hours
5	p Æ	Iner	if any, leading to immediate cause. Enter Underlying			7,000
वाहत	end end il-trans	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of the consequence of th	ence of);		
66- 8760,	bu icie		d	·		
. 9	ntificate ng phys s as the	Physician/Medical	IF FEMALE:			1000-0000-0000-000
4 14 Box	eath certific attending p for use as	lan/I	23b. Was decedent pregnant in the past 12 months?	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	at the de by the o	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown 9 ☐ Unknown	atti S Ottiel (specily)		
S, P	res that igned to be deta	by PI	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		to use contribute to the cause of death?
Jester Records,	w requir been si should I	eted			1 🗆 Yes	
Rec	has b	Completed			24a. Was an autopsy performed:	
		9	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☐ ith (Check only one)	No 1 Yes 2 No
herr of Vita	hysici his cer I direc	To B	examiner? 1 Yes 2 Hospital: 1 I patient 2 E	Others		6 ☐Other (Specify)
جhعتدم Division of Vital	Attending Physicien: r death. sctor: After this certification: by the funeral director.		1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	ijury occurred
/isic	Attency death	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	me, farm, street, factory, office		and Number or Rural Route Number,
Ď	tal or rs efte et Dire ed in t	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St.	a10)
	To the Hospital or Attending Phwitin 24 hours efter death. To the Funarel Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medicaf Examiner: On the basis of examinating and manner stated.	rledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	red at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
			> 54040	D41721		02/04/06
			30. Name and address of person who completed cause of death (Item STEPHAN PAVIOS MD		DR. SA	LISBURY MD 21804
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 -412	012. 3140	200. 1 2001
	Registr		FEB 0 6 2006 D	E. Rosett y		

314-66-9169

				State	of Marylar		artment of I ertificate of	Health and N <i>Death</i>		giene	16	04838
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month			3. Time of Death
	Physici /Medio		Elaine D. King						Februa	ry 4, 20	Yeer 106	12:25 am
	Examir		4e Fecility Neme (If not institution	n, give street end nu	mber)			4b. City, Town, or L				12 • 25 am
1		١.	Sacred Heart Ho	me				Hyattsvil	.1e	Princ	e Geo	rge's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	lest birthday,	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		334-01-1872	1□ M 2X F	89	Yrs.	Months Deys	riours Min.	Nov. 1	3, 1916	Illi	nois
	D .		Usuel Residence of Decedent		140 00	_						
	aryla	_	10a. Stete 10b. County		10c. Cit	y, Town or L	ocation				11	0d. Inside City Limits
	N T	5	Maryland Prince	George's	Hyat	tsvil:	le					1 X Yes 2 □ No
	it 2	蔶	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	death with the Maryland one 23e or 28e-f show if must be notified at	Funeral Director	5805 Queens Cha				20782			U.S.A.		
	e de	E I	11. Meritel Status	Armed Fo		,S. 13.	Was Decedent of I If Yes, specify Cub	Hispenic Origin? (Sp en, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Raci	e - Americak, White,	
20	filed within 72 hours efter Hygiena. ther than "naturel", or ite ent, the Medical Examine	by F	1 Never Married 2 Marri	If Yes, Gir	ve		1□ Yes 2⊠ No				U.S	
21215-0020	hour ure	8	3 X Widowed 4 □ Divorced	Year or D	ates:							
<u> </u>	n 72	Completed	15. Decedent (Specify only highes	's Education of grade completed)		16a. Dece	dent's Usual Occup kind of work done	petion during most of work ed)	ing	16b. Kind of Bu	siness/Ind	dustry
12	withi ana.	Ē	Elementery/Secondary (0-12)	College (1-4or 5+)	Homer		10)		0 11		
9	Hygir ther int,	Ö	12 17. Fether's Neme (First, Middle, I	Last)	-	nome	naker	18. Mother's Name	a (First Middle	Own Hor		
an	Mental Mental arked o	Be	Edward M. Dugan								9)	
Maryland	should and Men marke umatic	2	19e. Informant's Name/Relationsh		<u>.</u>	10h Mali	nn Address (Steen	Margare	et von (ccots	0444 70	0.41
2	d 2 s th en 7 ie i		Patricia King -					and Number or Run				
a)	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Depenment of Health end Mental Hylgiena. Inteportants if them 27 is marked other than "naturel; or itema 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	Daughter		JUUI lace of Dispo	Queens (Chapel Roa	Date	Mount 20c. Location -		
Baltimore,	Peges nant of I int: If ite		1 ☐ Burial 2 ☐ Cremation	3 X Removal from	State		osition (Name of matory or other pla	1			•	
	permit. Peg Depertmant Important: I any injury o	-	4 Donation 5 Other (Sp		For		rce Crema					Florida
Ba	permit. Depentri imports any inju		21. Signature of Funeral Service L	Z Z	1	1 2	2. Name and Addre			Funeral		
		_	H Consle	ance 1	Jase	h	4/39 Bal	timore Av	enue, n	yattsvi	ile,	MD 20781
-45	10.3		23a. Pert1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the deeth ech line.	n. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
A	Physician				7.	. /.						Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	3/7	9924	けんか	1/9				>)	rears.
		-	rosuming in death)		Due to (o	r as a consec	quence of):	. 1	7 3		4	
	Jsi ed	들		b. C6	nges	HIN	ehe	0x1-1/2	ailus	re '	74.	ears.
	end end	xar	Sequentially list conditions, if env. leading to immediate	,	Øue to (o	es a consec	quence of):	8			4	
68760,	ifficete be executed g physician end es the buriel-transit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	c. /-(y pe	81-8	48704			>	· 4.	ears.
287	phys phys s the	윷	resulting in death) Last		/ Due to (or	as e conseq	uence of):			(4	
	_ 0,0	-		d							i	
ROX	atten for u	Clar										
9	iaw requires that the deeth certif as been signed by the attending of should be detached for use ex	Completed by Physician/N	Part II. Other significent condition	ns contributing to de	ath but not resu	ilting in the u	nderlying cause giv	en in Pert I.	23b. Did t	obacco uee con	tribute to	the cause of death?
J	that the the second sec	4	Chronic	0656	ruch	ive	lun	a disea	se 101	/ee 2□ No	3 Prob	ably 4 ☐ Unknown
Kecords,	sign d be	g O	201	. 0			/	1			24h Wa	so outoney findings
Ď	neen Shoul	ete	ON-eagy	hen h	5:				perfor	an autopsy med?	ava	re eutopsy findings ilable prior to npletion of cause
စို ၂	has law	ם		7-: -	2							leeth?
= '	: The cate h		colon	anci	68.				1 🗆 Y	es 20800	10	Yes 2□ No
VITal	Avending Physician: or death. ector: After this cartific by tha funeral director,	au	25. Was cese referred to medical examiner?	Hospital:	U.7 *		100	26. Plece of Death	(Check only or	ne)		
5	this aldii	은	1 Yes 2 No 27. Menner of Death	1 1 1		ER/Outpatien		4 Nursing Hor		lence 6 Othe)
	After fune	<u>등</u>	Natural 5 ☐ Pending		h, Dey Year)	28b. Time of Injury	Wor		28d. Describe h	ow injury occurre	∌d	
<u>s</u>	death. ctor: A y tha fu	Cal	2 Accident investiga 3 Suicide 6 Could no	ot be	of Injune At he			Yes 2 □ No	204	Na	0	
	Direct of A	Certification:	4 ☐ Homicide determin	ned 288. Piece buildir	ng, etc. (Specify	me, tarm, str	eet, factory, office	1	City or Tow	itreet and Numbe n, State)	r or Hurei	Houte Number,
-	nospital or Attent 24 hours after deat Funeral Director: staly filled in by tha	Š	29a. Certifier 12 Certifying	Physician: To the	hast of my know	dodgo dogth	nonured at the tie	data d -l		(.)		
		edical	(Check only 2 Medical E	xaminer: On the ba and mann	sis of examinati	on and/or inv	estigation, in my o	ne, date and place, a pinion, death occurre	and due to the co ad at the time, c	ause(s) and mar late and place, a	nd due to	the cause(s)
	within To the comple		29b. Signature and title of certifier	Serve Hitalii	00)	29c. Licens	e number	2	29d. Date signed	(Month, E	Day, Year)
	->=0		KOIL	Cola-	1 C	10	0. 21	9609			06.	
	2		30 Name and address of parece	the completed and	of dooth /!!	220) /T	Print)	2001	0			
1			30. Name end address of person w	2 Y 7	RIFE	T M	OUNT	PAIN	20 14	LI MI	171	
ā-	Stat	6	31. Dete filed (Month, Day, Year)	32. Re	egistrer's Signat	ure	UUNI	K-MICHIE	16.1	11) 20	110	~
	Registra		FEB 0 7 2006	Blow)	& An	de						

State of Maryland / Department of Health and Mental Hygiene | | | For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:35 AM NIM Jun 2006 02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner MONTGOMERY 12630 ROCKVILLE VIERS MILL ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 \ M 2 \ F 215 06 6525 Director AUGUST 13,1927 S. KOREA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location worle 10d. Inside City Limits item 27 is marked other then "natural", or itame 23a or 28e-f ebov other treumatic event, the Madical Expresser must be redified at Yes 2 □ No Director MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12630 VIERS MILL ROAD APT 711 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within; th and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 12 PROPRIETOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RYU BYN KTM BAE Y CHO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Heelth ar Importent: if item 27 is any injury or other treu SOON DUNK HAN (WIFE) 12630 VIERS MILL ROAD ROCKVILLE MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NORBECK MEMORIAL 2/8/06 OLNEY MD Funeral Sel 21. Signatur 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV UPPER MARLBORO MD 20772 2303 KAYAK DR ter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 X No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred i or Attending P setter death. I Director: After Certification; 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours eff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) DANI Congression 511 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 31, 3:30 A^M 2006 ROSE LEAH COHEN KATZEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE MONTGOMERY CASEY HOUSE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F 84 579-16-6721 Director 02/08/1921 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28s-f ehow the Medical Examiner must be notified at POMPANO BEACH 1 XYes 2 □ No Director FLORIDA BROWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 CYPRESS BEND DRIVE SOUTH #419B 33069 or items 23a USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 XNo Yes, Give Specify: þ 3€ Widowed 4 □ Divorced Year or Dates: 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Depertment of Health and Mental Hygien important: If item 27 is marked other the eny injury or other traumatic event, the once. PUBLISHING CO. 4 TREASURER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BESSIE DINOFSKY SAMUEL COHEN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4500 DALY MANOR PL, OLNEY, MARYLAND DON KATZEN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 02/02/2006 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signatu 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEARS a MYELODYSPLASTIC SYNDROME resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Dav Year signed by the a 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1□ Yes 2X No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE ٥ 1 ☐ Yes 2X No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X atural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attanwithin 24 hours after deating the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D42452 feb 1, 2006 1.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 MUNCASTER MILLRD, ROCKVILLE, MD DR. CHITRA KAJAGOPAZ, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 03 2006 Registra

			1- For State of Maryland / Registrar	Depa Ce	artment of Heal	Ith and Me ath	ental Hyg	iene) () (5 04841
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Yea	3. Time of Death
	Physici /Media		George A. King				January	[,] 28, 2006	
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of D	eath
			13215 Grenoble Drive		Rockville			Montgo	mery
	Funeral Director		5. Social Security Number 6. Sex 131−28−8110 6. Sex 7. Age (In yrs. last to 70	virthday) Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 12/23/.	Year) 1935 N	Birthplace (State or Foreign Country) ew York
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Aaryli sho	5							1⊠Yes 2□No
	28a-	ect	Maryland Montgomery Rocky	1116	10f. Zip Code		1	0g. Citizen of What	Country?
	with	<u></u>	13215 Grenoble Drive		20853			USA	odani, y
	death ms 2;	era	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispan	nic Origin? (Spec	ify Yes or No-		mencan Indian,
336	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any in ury or other treumatic event, the Medical Examinar must be routiled at once.	by Funeral Director	1 Never Married 2⊠ Married 1 Never Married 2⊠ Married 1 Nover Married Forces? 1 Nover Seve Norean 1 Nover Married Forces? 1 Nover Married Forces?		f Yes, specify Cuban, Me	exican, Puerto F pecify:	Rican, etc.)	Specify:	hite, etc. ucasian
Ŏ	2 ho	ted	15. Decedent's Education 16	a. Dece	lent's Usual Occupation			16b. Kind of Busine	
21215-0036	d within 7 giene. ir than "r the Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 E	life.	kind of work done during DO NOT use retired) Cronic Engit		9	Governme	nt Contractin
	e file al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)		18.	Mother's Name	(First, Middle, M	Maiden Surname)	
Maryland	Menta Menta Arked	2	Unknown		My	yra Vanh	ousen		
a	2 she and ls m				ig Address (Street and N				
	and ealth m 27				Grenoble Di			-	
O.	Yor of H		1 Rurial 2 X Cremation 3 Removal from State	егу, сгег	sition (Name of natory or other place)			20c. Location - City	or Town, State
Baltimore,	anmen orient: in ury		*4 □ Donation 5 □ Other (Specify) Ft. I. 21. Signature of Fyneral Service Licensee		1n Crematon				, Maryland
Ba	mp per grand		US G	1(Name and Address of mple Tribut 040 Rockvill	Le Pike;	Rockvi	ille, MD :	20852
			23a. Part1. Enter the disease, or complications that caused the death. Di shock, or heart failure. List only one cause on each line.	not ent	er the mode of dying, su	ch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Lung Cancer						
	Examiner		Due to (or as a consequence	e of):					
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsees of Your y that initiated events c.						
o,	an an	Exa	resulting in death) Last Due to (or as a consequence	e of):					-
68760,	icate be executed physician and s the burial-transit	dicai	d						-
	ntifica ng ph as t	0	IF FEMALE:						
.O. Box	law requires that the death certific. as been signed by the attending pl 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Records, P.	uires that n signed t Id be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause given in	Part I.			to the cause of death? Probably 4 \(\bar{\text{N}}\)Unknown
000	s been si s should	ojete					24a. Was a		autopsy findings available
Re	9 4 9	Completed					autops perform		
Vital	Physicien: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?		26.	Place of Death	1		
of V	y s	Jo.	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	utpatier	t 3 DOA Other: 4	☐ Nursing Hom	e 5⊠Reside	nce 6 Other (S	pecify)
n O	ding Ph h. After th funeral	on:	27. Manner of Death 1 St Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b	Time of Injury	28c. Injury at Work?		3d. Describe ho	w injury occurred	
Sic		icat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes		74 I		S / S /
Division	tel or A	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	rarm, str	eet, factory, office	20	City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death ind/or in	occurred at the time, da restigation, in my opinion	ate and place, ar n, death occurred	nd due to the ca d at the time, da	tuse(s) and manner ate and place, and o	as stated. lue to the cause(s)
		Σ	29b. Signature and title of certifier		29c. License nun		25	9d. Date signed (Mo	onth, Day, Year)
)	10 1		Jones Kully	M	> D39	190		1/30/2006	
			30. Name and address of person who completed cause of death (Item 23a	(Туре,	Print)				
			Garrett J. Reilly, M.D. 3418 0	land	wood Court	#111; O	lney, M	laryland 2	20832
	. Sta Registr		31. Date filed (Month, Day, Year) 32 egistrar's Signature FEB 0 3 2006	A STATE OF THE PARTY OF THE PAR	cale				
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Registrar

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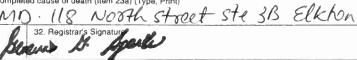
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 1:20 PM omara Deorge February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner IKton Hospita 6. Sex CCI nion If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 178-05-6648 1 M 2□F 9 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Madical Examiner past be notified at Castle 1 TYes 2 No ockessin Director New 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 10 items 23a aire states 100 Inited Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kailroad Crossing Watchman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Komara Wallace daught 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/ elationship (Type, Print) 100 Roeper 19701 Bear. f Health item 27 I larie 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 Removal from State All Saints Cemetery Feb 8, 2006 Wilmington. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of 633 Churchmans PH Keon Newa: K DE 19703 feeley Funeral Home 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician piration disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Ves 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably Anknown 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2200 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 200 npatient Certification; To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 latural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 🕽 🗠 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Avani



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00063720

			1 - For State Registrar	State of Marylan		artment of H rtificate of L			giene Reg. No.	006	04845
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic		Jane	I.	Lu	sby		February		006	9:15 P M
	Examin	er	4a. Facility Name (If not institution, give	,		4b. City, Town, or	Location of Dea	th	4c. C	ounty of Death	
			Clinton Convalescent			Clinton				ince Geor	0
B	Funeral Director		5. Social Security Number 6. Sec 1577-44-7431	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		th ay, Ye <i>ar)</i> 1934	9. Birth Cou Washi	place (State or Foreign intry) ngton, DC
	pu ,		Usual Residence of Decedent								
	anyla ehov	=	10a. State 10b. County		y, Town or Lo	cation					10d. Inside City Limits
	188-1	ecto	Maryland Prince G	eorges Bra	ndywine						1 ☐ Yes ZXXNo
	with a or	D	10e. Street and Number 10505 Cedarville Ro	1 Boy 810		10f. Zip Code 20613			_	on of What Cou	ntry?
	eath	eral			6 12.1		i- O-i-i-2 //	34	US		and to disc
36	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or Hems 23e or 28e-1 ehow event, II a Madical Exterili wrf. ust Le natified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes of No to Rican, etc.)		Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	hou	ed t	15. Decedent's Edu	Year or Dates:	16a Decer	lent's Usual Occupa	ation		, , ,		
5	n "ne	Completed	(Specify only highest grad	completed)	(Give	kind of work done of OO NOT use retired	furing most of wa	orking		of Business/Ir	Public
212	y with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cafet	eria Wor	ker			ol Syst	
מ	Hygie other	മ	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,			Cili
Maryland	should be filed within and Mental Hygiene. marked other than umatic event, ILAM.	To B	George	Corb	in		Virgini	.a		Gr	imes
an D	2 sho and i		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a			er, City or	Town, State, Zij	Code)
	and ealth m 27		Deborah Lusby-Teagu			oeka Rd.,	Connowi	ngo, MD	21918	3	
Baltimore,	ges 1 t of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		lace of Dispo cemetery, cren	sition (Name of natory or other place	e) Feb.9	,2006	20c. Loca	ation - City or T	own, State
텵	t Pa tmen tant:		`4 ☐ Donation 5 ☐ Other (Specify)	Was		on Nation	al Çem.			Land, Ma	
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en 2008.		21. Signature of Funeral Septime License	2		Name and Addres				neral Hom and 207	e_PA 45
П			23a. Part1 Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat e cause on each line.	h. Do not ente	er the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ARTHEROS	SCLER	20716	ARDIOV	45 CULA	R DIS	SCASE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
h		-0	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uance of):						
	uted J Insit	Examiner	Cause (Disease or injury	220 10 (0. 20 2 00.000	301100 017.						
Ć.	execting and in and inal-trial	Еха	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
68760	icate be executed physician and s the burial-transit	edical									
_			IF FEMALE:								
Вох	th ce tendi	an/M	23b. Was decedent pregnant 2	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23	d. Date of deliv	•
0	The law requires that the death certii le has been signed by the atlending age 2 should be detached for use a	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d		Other (specify)				Month	Day Year
٦.	hat the side by detact		Part II. Other significant conditions con	tributing to death but not rec	ulting in the ur	doshina opuso sura	o in Part I	230 Did t	abassa usa	contribute to t	he cause of death?
Records,	signed I	d by	END STAGE RE			identyllig cause give	miniranti.		Yes 2 🗆		pably 4 Winknown
Š	w require been sig should b	lete	HYPERTEN SION	_		14=11×±11	(
Re	he lay a has	Completed	HINDE I BY DION	, PARCI		MELLITU	حــــــ	24a. Was autor perfo			ppsy findings available impletion of cause of
Vital		e Co	25. Was case referred to medical					1 Tes	2X No	1 ☐ Yes	2 □ No
	ysicia is cert directe	00	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ED/Outrati-	Othe	г	ath (Check only o		70	
ō	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 MANUISING F	dome 5 ☐ Resident			(y)
Division	Attending Physician: or death. ector: After this certific by the funeral director,	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □No				
N S	ar der recto by th	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office				Number or Rura	al Route Number,
ā	Ital or rs afte ral Dir	Cer		Building, Glo. (Opposi)				City or Tov	wii, State)		
	To the Hospital or Atten Within 24 hours after deat Vothe Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occi	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier		٥.	29c. License				signed (Month,	
A	(1)		1 mur)	ATTENDMG	MYSIU	An D5	2900		02-	·06 - Z	000
	You C	Ì	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)		IN 0.11		0 3 4 -	7.25
	0		MUSA MOMOL			RAL A	U, LAN	D OV CH	c M	0 207	185
	Sta Registr		31. Date filed (Month, Day, Year) FFR 0.7 2006	32. Registrar's Signa	ture						

		•	For State Registrar		State	of Mar	rylan	d / Depa <i>Cer</i>			ealth a Death	and M	ental I	Hygie Reg.	Ga U	06	04846
	nysicia Medic		Decedent's Name (First, Mid Virginia M.									1	2. Date o Month Febru		Day	Year 2006	3. Time of Death 11:05 AM
	xamin		4a. Facility Name (If not institut The Annapolit			,	vino	7	4b. City		Location o	f Death				unty of Deat	
	neral ector		5. Social Security Number 212-42-5325	6. Se		7. Age (last birthday) Yrs.	If Unde Months	r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date o (Month	, Day, Yo		9. Birt	hplace (State or Foreign untry) aryland
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene ther than "natural", or tiems 23e or 28e-1 show	offfied at	Director	Usual Residence of Decedent 10a. State Maryland 10b. Coun Que 10e. Street and Number	-,	Anne's	1	10c. City	y, Town or Lo			onvi]	lle		· · · · · ·			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with t	resal for r	erai Dir	100 Canal Stre	et	12. Was Dec		in 11	6 42 1		Code	21638				U	of What Co	
0036 ours after de	Exambles	by Fur	11. Marital Status 1 □ Never Married 2 □ M 3 ☒ Widowed 4 □ Divorc		Armed F	orces? 2⊠No iive			Yes, spe	_	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	lican, etc.)		Black, White	
21215-0036 d within 72 hours af gliene.	aumatic event, i'ra Medical Exarta ar itwal be tudified at	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	est grac	e completed,	(1·4or 5+))		lent's Usu kind of wo OO NOT L	ork done d se retired	ition furing most)	of workin	g	161		of Business/	,
Maryland and a strength of the	atic event,	To Be C	17. Father's Name (First, Middle Marion Dill								18. Mothe		(First, Mic r Sm.				O.I.C
≥ ⊵ક્ર	other traumatic		19a. Informant's Name/Relatio Marion Lamb								nd Numbe treet					own, State, 2 arylai	Zip Code) nd 21638
	ury or oth		20a. Method of Disposition 123 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other			State	Cé	lace of Disposementery, crem Crest	natory or	other place			/2006				Town, State Maryland
Baltimo	any injury or o		21. Signall Tuneral en	Licens	** X	U	Le										al Home , MD 21401
Physi /Med Exam	dical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or comp st only o	a	caused the each line. MM (or as a company)	il.	Bowe						ry arrest			Approximate Interval Between Onset and Death
8760, cate be executed	no	Еха	b. Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):														
BOX 6 ath certific	or use as	Physician/Medicai	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)										23d. Date of delivery Month Day Year			,	
rds, P. quires that	should be detached	٦	Part II. Other significant condi	tions co	ntributing to o	death but	not resu	ulting in the un	derlying	ause give	n in Part I.			oid tobac	2 N		the cause of death?
DIVISION Of VITAI RECORDS, for Attending Physician: The law requires to effer death. Director: After this certificate has been signs.	age 2	Completed											a	Was an autopsy performed as	d?	4b. Were au prior to death? 1 Yes	topsy findings available completion of cause of
of Vital I hysician: Th his certificate	director.	To Be	25. Was case referred to media examiner? 1 ☐ Yes 2 No		Hospital: 1 🗆	Inpatient	2 🗆 1	ER/Outpatient	3 D	Othe	26. Place ^{or:} 4 □ Nui		Check on	10		Assist Other (Spec	
DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certifica	the funeral		27. Manner of Death 1 Natural 5 ☐ Pend 2 ☐ Accident invet 3 ☐ Suicide 6 ☐ Coul	tigation		nth, Day Y		28b. Time of Injury	М		at ? ′es 2 □ N	No	8d. Descr				
DIVI	lled in by the f		4 Homicide dete	mined	build	ding, etc.	(Specify						City of	Town, S	State)		ral Route Number,
the Hospital nin 24 hours e the Funeral I	completely filled in by	Medical	(Check only 2 Medic one)	al Exami	ner: On the I	e best of basis of e nner state	xaminat	wledge, death ion and/or inv	estigation	ı, in my op	inion, deat	d place, a th occurre	nd due to d at the ti	me, date	and pla	ce, and due	to the cause(s)
or with or	000	4	29b. Signature and title of certification in the second se	1 N	relser	MI	0			D2	number 86	7		1		gned (Monti 2 - C	h, Day, Year)
			30. Name and address of personal Thomas V					23a) (Type, I ula Fa		oad	Arnol	d. M	D 21	1012			
Ro	Sta egistra		31. Date filed (Month, Day, Yea		70.1	C	- 01	Lure A									

			1 - For State Registrar	State of M	larylar				lealth a D <i>eath</i>	and M		giene () Reg. No.	06	04847	
	Physici	an	1. Decedent's Name (First, Middle, La	LE4SK							2. Date of De. Month Februa		2006	3. Time of Death	
	/Medic		4a. Facility Name (If not institution, gir				4b. Cit	, Town, or	Location of	of Death	rebrua		LUU0	8:55 A M	
		Ü.	Civista Medical	Center					Plata				rles		
	Funeral Director			Sex 7. A 1 □ M 2 A F	ge (In yrs. 65	last birthday) Yrs.	If Und Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da OCT. 2	3, 194	9. Bir Pen	thplace (State or Foreign ountry) nsylvania	
	yland now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	8a-1 el	ctor	Maryland Charle	!S		Wal	dorf							1 ☐ Yes 2 ☑ No	
	with ti	Funeral Director	10e. Street and Number 823 Copley Avenu	ie.			10f. Z	ip Code 206	502			10g. Citizen	of What Co	ountry?	
	death	nera	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Dec	edent of Hi	ispanic Ori	gin? (Spe	crfy Yes or No Rican, etc.)	- 14.		erican Indian,	
30	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Itams 23e or 28s-f ehow event, the Medical Examiner must be notilled at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X If Yes, Give	No No			v	Specify:	i, rueito i	rican, etc.)		Black, White Breity: Wh		
3	2 hour atural		15. Decedent's E	Year or Dates		16a. Dece	dent's Us	ual Occupa	ation				Kind of Business/Industry		
212	ithin 7 ne. "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	a <i>de completed)</i> College (1-4or	5+)	life.	DO NOT	use retired	during mos	t of workii	ng		0 1		
2	filed w Hygier other th		17. Father's Name (First, Middle, Las	1)		Hom	ema k	er	18 Mothe	ar's Name	(First, Middle,		Own H	ome	
<u>la</u> n	e d la b	To Be	Edward Robert Bra								h Spin				
Maryland 21215-0036	s 1 end 2 should f Health and Men Item 27 is marks other treumatic	- 1	19a. Informant's Name/Relationship			1					Route Numbe	-		Zip Code)	
	s 1 end / Health tem 27 other tr		John Richard Leho	sky – Hus	20b. F	Place of Dispo	sition (N	ame of	1		lorf, M			Town, State	
Ē	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Tr	cemetery, crei 'inity	matory or Memo	other plac rial	Gdns	2-9-	-06	Waldor			
Baltimore,	permit. Pages Department of I Important: if It any Injury or o onca.		21. Signature of Funeral Service Lice	How MOOO	53				ss of Facilit		3035 0 Waldor		_	on Road	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	ed the deat	th. Do not en	ter the mo	de of dyin	g, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Between	
T	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aCORO Due to (or a	WAR	y AM	707	14	DISE	ast				Onset and Death	
ı	Examiner			Due to (or a	s a consec ERO	Juence of): SCLE	ROS	1)							
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	Due to (or as a consequence of): 1) ABETE AND CLARETTE ANDICTES										
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):										
8/60	icate be executed physicien and s the burial-transit	dical E	(_d	Sevene obestry								- 1		
٥	ertifica ling ph e as th	Med	IF FEMALE:	"											
X R R	eath certifii ettending p for use as	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth 4☐Pregnant	2 Feta	Ideath 3	Ectopic Other (pregnancy				23d.	Date of de Month	livery Day Year	
J.	of the de by the tached	hysl	1 ☐ Yes 2 ☑ Ño 9 ☐ Unknown	9 Unknown	at till 0 01 t		3 0(1161).	pocny/							
Vital Records, F	The law requires thet the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions ASUPIDEMIA	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to			o the cause of death?	
ဓင္ပဝ	law re as bee	plet	COPD								24a. Was	an 24	b. Were a	utopsy findings available completion of cause of	
E E	iclan: The law certificate has I rector, page 2 s		/								perfo	2 No	death?	2 12 No	
	rsician: s certific director,	To Be	25. Was case referred medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital:	iont 2	ER/Outpatier	nt 3□ 0	Othe			<i>(Ch</i> eck only one 5 ☐ Residue)		Other /C-		
Ö	ding Phy h. After thi funeral o		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of In (Month, D		28b. Time o		28c. Injun Work			28d. Describe I			Chy)	
Division of	ttendli death. stor: A	catl	2 Accident investigation 3 Suicide 6 Could not I	on			М	10	Yes 2 □		204 1	2			
	effer a line by	Certification;	4 Homicide determined	286. Place of it	atc. <i>(Speci</i>	ome, rarm, str fy)	reet, facto	ry, office		•	City or Tox	Street and No wn, State)	imber or R	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certifica completely filled in by the funeral director, it	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the bes miner: On the basis and manners	t of my kno of examina stated.	owledge, deat ation and/or in	h occurre vestigation	d at the timen, in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and date and pla	manner as	s stated. a to the cause(s)	
	within To th comp	Me	29b. Signature and titte of pertifier	1//			2	9c. License	number			29d. Date si	ned (Mont	h, Day, Year)	
) //h	1 M				D	5 + 4	-6=	+	21	6/	06	
(KR 17		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	WASE	+1NG-	6H	RD (5	# 3010 1	Was	to the cause(s) th, Day, Year) OG LONF MO 20602	
-	Sta		31. Date filed (Month, Day, Year)	32. Pagis	trar's Sign	ature	/ .		7					402	
	Registi	ar	FEB 0 7	200fl 🚜	Was	10. 16	DEL								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 830/ **Physician** Month ELSIE LOWERY 06 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SGNBC 9701 MEDICALCENTER DAVE ROCKVILLE MONISOMER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2MF 218-20-1652 Director 02 - 08-1925 Maryland Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? Is merked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Directo 1 ☐ Yes 2 1 No Maryland | Montgomery Boyds 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 20814 21014 Clarksburg Road Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Year or Dates natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) 10 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Carrie Edna Ricketts Charles Benjamin Coleman 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walkersville, Maryland 21793 <u> Benjamin Doyle Lowery - S</u>on 10802 Dublin Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metropolitan Crematorium 2/3/06 Alexandria, Virginia 4 □ Dopation 5 □ Other (Specify) 21. Signature of Fur ral Service Licens 22. Name and Address of Facility.
Molesworth-Williams P.A., Funeral Home overt 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Conen/10 Examiner Due to (or as a consequence of) Examiner Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate 1LI Yes 2EINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred ours effer deau.

*I Director: Ah.

in by the fur-1 Maturel 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 3/1 time end address of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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32. Regi

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Vaa **Physician** Deloris Delria Lewis February 1, 2:30 P.M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1937 | 9. Birthplace (State or Foreign (Month, Day, Year) 1937 | 9. Birthplace (State or Foreign (Month, Day, Year) 1937 | 1. Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🕱 F 68 Yrs. 577-82-9766 October 24, Jamaica, Indies Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-fehow the Medical Examiner must be notified at 1XYes 2 □ No Directo Prince Georges Hyattsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö United States 6640 - 24th Avenue 20782 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Westwood Retirement ifiled within 7. Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Domestic Engineer 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ss 1 and 2 should be fi of Health and Mental F item 27 Is marked of Emilin Smith Levi Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 Judith Vivienne Cartwright-Ransay(daughter)6640 - 24th Avenue:Hyattsville,Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 11, 2006 permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland Name and Address of Facility
R. N. Horton Company Morticians, Inc. 21. Signiture of Funeral Service icensee 600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 18miar Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760 Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | ☐ Yes 2 No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1□ Yes Division of Vital Hospital or Attending Physician: funeral director 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 ER/Outpatient 3 DOA Inpatient this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 Natural 2 Accident death. 1 Yes 2 No investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the Vithin 2 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complet ise of death (Item 23a) (Type, Print) State Registrar FEB 06

			1- State of Maryland / Der FH G860 10/12/06 JH	partment of Health a ertificate of Death	nd Mental Hyg	giene Reg. No.	04850
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Year	3. Time of Death
	Physicia /Medic		Ruth C. Lynch			ry 6,2006	10:00a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	f Death	4c. County of Death	
			216 Rhett Lane	Elkton		Cecil	
	Funeral		2290-15-4-19209 r 6. Sex 7. Age (In yrs. last birthd	Months Days Hours	Min. 8. Date of Birt (Month, Da)	9. Birth (28, 1914	place (State or Foreign ntry)
	Director		212-01-2170 TIM ZAIF 91 Yrs		April	28,1914	MD
	and w		10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits
	Mary	jo	MD Cecil Elkto	on			1 ☐ Yes 2 ☑ No
	the 288	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?
	3a o	O I	216 Rhett Lane	21921		U.S.A.	
	death	Jer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - Ameri	
9	after or ita	by Funerai	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 St No Specify:	, Puerto Piloari, etc.)		hite
8	hours after death with the Maryland tural', or itams 23s or 28s-f show al Examinat must be rediffed at	d b	3 XVidowed 4 ☐ Divorced Year or Dates:	12.100 2 4 (100 00000).		Specify. VV	11106
2	72 h "natu	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most b. DO NOT use retired)	of working	16b. Kind of Business/Ir	ndustry
2	within ne. han	mp	Elementary/Secondary (0-12) College (1-4or 5+)			Real Est	ate
22	Hygie Hygie ther t		12 1 B.	coker	r's Name (First, Middle,		
auc	d be i) Be	Authur Rickey		zabeth Mi		
Maryland 21215-0036	shoul nd Me mark mati	7		ailing Address (Street and Number			o Code)
S	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event. The Medical Examinating restrictions.		Carol Malmstrom/Daughter 21	Rhett Lane,	Elkton,	MD 21921	
altimore,	s 1 a of Hei item othe		cometen	sposition (Name of rematory or other place)	Date	20c. Location - City or T	own, State
Ë	Page nent c int: if		1 M Burial 2 Ucremation 3 Unemoval from State	Comptess	bruary 9,	Aberdeen	, MD
Balti	permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau 2002.		21. Signate to of Foregraphy Service Licensee	22. Name and Address of Facility Andrew G. Ge	e Funeral	Home	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying such as o	State of respiratory ar	on, MD 2	1991 Approximate
П					0///	.//	Interval Between Onset and Death
}	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a	177179	01581	36	unk
	Examiner			/			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cuted	Examiner	Cause (Disease or Injury that initiated events c.				
Ö,	e exe		resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical	d				
9 ×	that the death certific ed by the attending to detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of dolla	
Bo	atten atten for us	ian	in the past 12 gronths?	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	Day Year
P.O. Box	The law requires that the death certifi ate has been signed by the attending, page 2 should be detached for use as	ysic	1 Yes 2 No 9 Unknown	Janon (specify)			
٣.	that led by deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	w requires that been signed to should be deta	d by	CULUN CANUER		101	res 2□No 3□Pro	bably 4 dnknown
O O	s bee	Completed			24a. Was	an 24b. Were aut	opsy findings available
	sician: The law s certificate has b lirector, page 2 s	mo			autop perfo	rmed? death? 2 No 1 ☐ Yes	ompletion of cause of
Vital		Be C	25. Was case referred to medical	26. Place	of Death (Check only o		
\leq	Physician: r this certifica ral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nur	rsing Home 5 Resid	dence 6 Other (Speci	(y)
0	ng Phys ter this neral di		27. Manner of Death 1 → Natural 5 → Pending (Month, Day Year) 28b. Tim (Month, Day Year)		28d. Describe h	now injury occurred	
0	endin eath. or: Ai	catio	2 Accident Investigation	M 1 Yes 2 N			
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (S City or Tox	Street and Number or Rur vn, State)	al Route Number,
	spital ours ours reral filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, d	eath occurred at the time, date and	d place, and due to the	cause(s) and manner as	stated.
	e Hos 124 h 16 Fur letely	edical	(Check only one) 2 Medicel Examiner: On the basis of examination and/one) and manner stated.	investigation, in my opinion, deat	th occurred at the time,	date and place, and due	to the cause(s)
	withir To th	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,	Day, Year)
•			Del Serte 31	0 292	-21	2/6/2	2006
	17		30. Name and address of person who completed cause of death (Item 23a) (Ty				
	1 1		Dr. Gary Best, 313 W. Mai		rk.De.		
	Sta Registr		FEB 0 8 2006 Steem St. Registrar's Signature	,			

			1- State of Maryla	and / Department of Health and M Certificate of Death	fental Hygiene 06 04851										
t	Physici	an	Decedent's Name (First, Middle, Last)		2 Date of Death Apple 1 2006 3. Time of Death Apple 2 25 Am										
	/Media	al	Isabella Doris Mahaney 4a Facility, Name (If not institution, give street and number) T	467City, Town, or Location of Death	4c. County of Death										
	Examir	er	JOHNS HOPKINS HOSPIL	AL BALTIMORE C	LITY										
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)										
	Director		N/A Usual Residence of Decedent	2 44	Jan. 31, 2006 Baltimore, MD										
	aryland	_	10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limits 1 ☆ Yes 2 □ No										
	the Ma	Director	Maryland Anne Arundel	Odenton 10f. Zip Code	10g. Citizen of What Country?										
	h with	i Dir	2702 Cherrywood Ct.	21113	USA										
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow or other traumatic event, the Marked Exactinar matter by mulliad at	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2€ No Specify:	acify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White										
2-0	72 hou nature	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business/Industry										
121	within ene then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) NONE	NONE										
land 2	uid be filed lental Hygi rked other	To Be Co	17. Father's Name (First, Middle, Last) Shawn J. Mahaney		a (First, Middle, Maiden Surname) P. Erbe										
Mary	nd 2 should lith and Men 27 Is marke r traumatic		19a. Informant's Name/Relationship (Type, Print) Shawn J. Mahaney/ Father	19b. Mailing Address (Street and Number or Rura 2702 Cherrywood Ct.	al Route Number, City or Town, State, Zip Code) Odenton, MD 21113										
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	t. Lincoln Cemetery Feb.											
Balt	permit. Pa Departmen Important: any Injury		21. Signature/of Funeral Service Licensee Maxte	22. Name and Address of Facility Bea	ll Funeral Home Bowie, MD 20715										
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac of	or respiratory arrest, Approximate Interval Between Onset and Death										
)	Physician /Medical		sease or condition sulting in death) Due to (or as a consequence of):												
	Examiner		Sequentially list conditions, b. Preterm	Premature Rustine of A	lembranes 7 days										
	pe sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):											
Ć.	cate be executed ohysician and the buriai-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a cons	sequence of):											
8760,	ate be hysicia the bur	dicai	d												
P.O. Box 6	ath certifi	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year										
ds, P.	uires that the de signed by the a ld be detached t	d by Ph	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
Division of Vital Records,	sician: The law requir certificate has been si rector, page 2 should	ompiete	Tracheo-esuphageal	fistula	24a. Was an autopsy performed? 1 Yes 2 16 Yes 2 No										
/ital	clan: ertifica ector, p	Be	25. Was case referred to medical examiner?		h (Check only one)										
ð	hya this aldi	: To			me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred										
ion	nding ath. r: Afte	ation	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury Work? M 1 Tes 2 No											
Divis	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined building, etc. (Special Could not be determined building).		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai (knowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)										
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										
)		30. Name and address of person who completed cause of death (I	tem 23a) (Type, Print)	-/ UQ U 1000										
1	_		ERNEST GRAHAM THE JOHN	s Hopkins Hospital 600 1	N WOLFESTREET BALTO, MD 21287										
1	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2006	B. Aparlie											

		•	For State Registrar		State of M	laryland	-	artment of <i>tificate of</i>				giene Reg. No.	06	04853	
	Diversity.		1. Decedent's Name (First, Middle, I	Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death	
١	Physici /Medic		JAMES		WALTER		M.	AYBIN			FEB. 1,	_200	6	7:08 AM	_
I	Examin	er			give street and number)		4b. City, Town,					County of Deatl		
			5. Social Security Num			ge (In yrs. las	st birthday)	TEMPLE If Under 1 Year			8. Date of Birtl		1NCE GE		_
	Funeral Director		220-70-8		1 X M 2□F	48	Yrs.	Months Days	Hours		(Month, Day 1-8-57	/, Year)		hplace (State or Foreign untry) HESDA, MD	
	P		Usual Residence of D	ecedent							7-0-21		- DC11	· · · · · · · · · · · · · · · · · · ·	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow dical Examinar must be notified at	ž		10b. County	GEORGE		Town or Lo	HILLS						10d. Inside City Limits 1 Yes 2 No	
	the M	Directo	10e. Street and Numb		GLUKGL	1 1	MILL	10f. Zip Code				10g Citiza	en of What Co		
	with		4966 KEP		MO				0748				S. A.	undy.	
	72 hours after death with "natural", or Items 23a or edical Examinar must be	Funeral	11. Marital Status	FLLK KL	12. Was Deceden	Ever in U.S.	13.	Was Decedent of f Yes, specify Cu		rigin? (Spe	cify Yes or No-		4. Race - Ame		_
9	or Ite		1 Never Married	2 Married	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	No		r Yes, specπy Cu 1 □ Yes 2 🕱 No			tican, etc.)	1	Black, White		
1215-0036	ural',	d by	3 Widowed 4		Year or Dates					·			Specify: BLA		
Ÿ	"natu	Completed	1. (Specify	5. Decedent's only highest	Education grade completed)		(Give	tent's Usual Occu kind of work don DO NOT use retir	e during mo	st of workin	g	16b. Kin	d of Business/I	Industry	
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2	i filled I Hygi other	Be Co	17. Father's Name (Fi		st)		6 1110	2010	18. Moth	ner's Name	(First, Middle,				
Jan	should be filed nd Mental Hygin markad other umatic event, I	To B	ANDREW	MAYBI	N, JR.				9	MELMAI	RIE	G	RAY	·	
Maryland 2	2 au		19a. Informant's Nam		(Type, Print) GSSISTER			ng Address (Stree			Route Numbe	. ,		,	
	Health Health tem 27		20a. Method of Dispos		/33131LK	20b. Plac		sition (Name of a			ate IIIL		ation - City or		_
ē	0 0		1 Deurial 2 □		☐Removal from State cify)	3 1		NAT. MEN		2-11-	-06	LAURI	EL, MD		
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Fund	oral Service Lic	censee		22	. Name and Add	ress of Faci					IERAL HOME	
	<u>0</u> 05 a d		/head	occ.	linckne	4		4 - 8TH				-	C 20002	Approximate	
					omplications that causely one cause on each				ring, such a	s cardiac or	respiratory an	rest,		Interval Between Onset and Death	
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	sjr.	e	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty												_
	outed nd ransit	Examiner	Cause (Disease or injury that initiated events												
Ö,	cate be executed physician and the burial-transit		resulting in death) Las	st	Due to (or a	s a conseque	nce of):								
8/60	ate by hysic the bu	dical	d												
9 ×	death certifica e attending phad for use as t	/Med	IF FEMALE:		23c. If yes, outcom	e of pregnance	21/			-	-				
ROX	attender for us	lan	23b. Was decedent p in the past 12 m	onths?	1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pregnan Other (specify)	су			23	3d. Date of deli Month	Day Year	
o.	0 0 0	Physician/Me	1 Yes 2 M 9 Unknown	No	9□ Unknown	at time or doa	.ai 0_	g datet (apocii))							
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Vital Records,	quires in sign uld be										1 🗆 Y	es 2	No 3□Pro	obably 4 DUnknown	
000	> 0 0	plet									24a. Was autop		24b. Were au	topsy findings available completion of cause of	
ř	Ф С В	Completed									perfor	med2 2 No	death?	2 No	
<u>I</u>	ician: Th certificate rector, pag	Be (25. Was case referred examiner?	d to medical		-				ce of Death	(Check only o				_
ot o	Physician: r this certific ral director,	2	1 ☐ Yes 2 No	0	Hospital: 1 ☐ Inpat		R/Outpatier				e 5 Resid		Other (Spec	cify)	_
	Ing After une	tlon:		5 Pending	28a. Date of In (Month, D	ay Year)	8b. Time of Injury	W	uryat ork? ⊡Yes 2.[8d. Describe h	ow injury	occurred		
DIVISION	deat deat ctor: y the	flcat	2 Accident 3 Suicide	investigat	t be 28e. Place of Ir	niury - At hom	e, farm, str	eet, factory, office		-	8f. Location (S	Street and	Number or Ru	ıral Route Number,	-
2	To the Hospital or A within 24 hours after to the Funeral Direction plately filled in by	Certification;	4 Homicide	determin	building,	itc. (Specify)		,,,			City or Tow	m, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 (Check only 2	Certifying	Physician: To the bes	t of my knowl	edge, deat	occurred at the	time, date a	and place, a	nd due to the	ause(s) a	and manner as	stated.	_
	To the H within 24 To the Fi complete	ledical	one)		and manner s	tated.	in and/or in								
	To To	Σ	29b. Signature and tit	le of certifier				-	nse number				signed (Month		
	(a)		hu	n-Mu	ing pe	7	–	\mathcal{D}	521	43		te	622	.00D	_
-	(8)		30. Name and addres	s of person wh	no completed cause of 4 T30 M	V .	?За) (Турв, 22/	Print)	· / a 15	1:10	1040	, .	lama	.00b MD 2011	21
	Sta	te	31. Date filed (Month,	Day, Year)	22. Regis	trar's Signatu	18	10/61	C 80/11	116	-une	• /	Lugo		_2
	Registr	10.00	FEB	0 6 200	6 Person	JK;	Anna	E,							
					•		F								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** MOORE 30 06 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner RINGCIALE caa If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Yeer Months 9-48-4575 1 □ M 2 🗷 F SHE/BY Yrs. Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or frems 28 or 28a-f show any injury or other traumatic event, if a Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No RINGAALE **Funeral Director** JEORGES 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Tates nitea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bluefield Springdale, (nI). 201 COWGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REMOTOR 22. Name and Address of Facility 21. Signature of Funeral Service Licensee m01178 enu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Physician/Medical Examiner vere anem within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit or Attending Physician: The lew requires that the death certificate be exacuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 230 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medicai Certification: To 1 Inpatient 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury et Work? 5 Pending investigation Injury 1 Naturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier MID D006 06 211 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) MD MD20770 Belle MEKLIT WORKNE H 31. Dete filed (Month, Dey, Year) Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

FEB.03 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per Dr., G85404/17/06dhb

Certificate of Death

Reg, No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2, 2006 Cathryn N. Martin February 3:05 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Vindobona Nursing Home Braddock Heights If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 13 F 040-16-5625 Nov 17 1910 New Haven, CT Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Knoxville 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21758 USA 628 Tritapoe Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No White Specify: 3 StWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yale University Switchboard Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Callahan Francis McNulty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Tritapoe Drive, Knoxville, MD 21758 Patricia Bruning, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) Hagerstown Crematory 2/5/06 Hagerstown, MD 21. Signate of Fundaments Service Licentes Williams, Uwner Barbara A. Williams, Uwner 22. Name and Address of Facility John T. Williams Funeral Home Williams, 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYGCHROIAL INFARCTION Due to (or as a consequence of): MINY YEATES SCOEMOTIC CARDIO DASCULAR NISEME HRTERIO Due to (or as a consequence of): ce of):

Physician /Medical Examiner

physician and s the burial-transit

as attending p

signed by the a

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certificate

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or Attending Physicien: after death. Director: After this certification

To the Hospital o within 24 hours af To the Funeral Di

Physician/Medical

à

Completed

Be

Certification:

certificate be executed

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

þ

Completed

Be

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Funeral

Director

?7 is marked other than "natural", or items 23s or 28e-f ahow treumatic event, the Medical Examinar must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny lighty or other treumatic event 90Rg.

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

c	Due to (or as a consequence
d	

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day

in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

24a. Was an

2 No 3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

Year

autopsy performed! 2X No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	Was case examiner?		-	medical
27.	Manner of	Death		

1 🗋 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Nursing Home 5 Residence 6 Other (Specify)

29a. Certifier one)

Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other:

29b. Signature and fitte of certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D16675

MY

29d. Date signed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day)

			1 - For AMEND#10 doe: TH2/10 Stete Registra MEND#19 bpc: TH2	State of Maryla /06, Ew, Moc /10/06, Ew, McC	and / Dep	artment of rtificate o	Health and f Death		iene 2.006	04856
	Physic	ian	1. Decedent's Name (First, Middle, Last James Allan					2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town	, or Location of Dea	Februar	y 2 2006 4c. County of Death	6:45 P M
	LAGIIII		4 Larkspur Way	ŕ			ithersbur		Montgome	
	Funeral Director		5. Social Security Number 215-54-1028 Usual Residence of Decedent	x 7. Age (In your 57) 7. 3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	rs. last birthday) Yrs.	If Under 1 Year Months Day			Year) 9. Birth Cou.	place (State or Foreign Intry) apan
	aryland show	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	the Ma	Funeral Director	MD Montgon	ery	Gai	thersbu				1 X Yes 2 No
	with t	Dir	10e. Street and Number 4 Larkspur Way			10f. Zip Code	20877		g. Citizen of What Cou	•
	death ms 2	nera	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent o	f Hispanic Origin? (Suban, Mexican, Puer		United Stat	
9036	d within 72 hours after death with the Maryland jiene. r then "natural", or items 23a or 28a-1 show The Madical Exactive roust be rediffed at	d by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No 1 0 If Yes, Give Year or Dates:	167	If Yes, specify Cu 1 ☐ Yes 2 🔀 N		to Rican, etc.)	Black, White Specify:	White
15 -	C 1 10	Completed by	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occ kind of work dor DO NOT use reti	e during most of wa	rking 1	6b. Kind of Business/In	ndustry
212	filed within I Hygiene. other then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 4			programer		FDA	
Maryland 21215-0036	othe /ent,	To Be C	17. Father's Name (First, Middle, Last) John Motz				18. Mother's Na	me (First, Middle, M Hamlin		
, Mary	and 2 sho baith and N 27 is ma er trauma		19a. Informant's Name/Relationship (Ty Heather Patterson		19b. Maili 7575	ng Address (Stree	et and Number or Road	urai Boute Number, Detour Deteru,	City or Town, State, Zi	o Code)
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other traumatic as once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ P '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	lemoval from State Me	tropoli Crema	. Name and Add	Feb. 200	ruary 6 06 eVol Fune:	oc. Location - City or T Alexandria ral Home, l urg, MD 208	ı, Virginia
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or compleshock, or heart ailure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ath. Do not ent	er the mode of dy				Approximate Interval Between Onset and Ceath 1 Year
68/60,	death certificate be executed e attending physician and id for use as the burial-transit	fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last							
P.O. Box	that the death certific led by the attending p detached for use as i	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnan Other (specify)	су		23d. Date of delive Month	ery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.		cco use contribute to t	
ř	: The law re cate has be , page 2 sho	Completed						24a. Was an autopsy performs	prior to co	psy findings available mpletion of cause of
<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				th (Check only one)		
ō	ding h. Afte fune	tion: To	1 Yes 2X No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 (28a. Date of Injury (Month, Day Year)	Z8b. Time of Injury	28c. Inji	ury at ork?	ome 5X Residen 28d. Describe how	ce 6 Other (Specific injury occurred	y)
DIVIS	tal or Atten	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, office)	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of my kner: On the basis of examin	nowledge, death nation and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the within : To the comple	Mec	29b. Signature and title of certifier	and manner stated.			ise number		f. Date signed (Month,	
	0+1		1 7600	6			D45880		ebruary 3,	
- (30. Name and add as a person who co Leon C. Hwang, M.D	.,1396 Picca	rd Driv	e, Rockv	ille, MD	20850		
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 6 20	32 Registrar's Sign	nature	will !				

			For State Registrar	State of Maryland	d / Depa		t of H		Mental Hy	giene Reg. No	000	14857
	, A		1. Decedent's Name (First, Middle, Las	it)					2. Date of D Month	eath Da	y Year	3. Time of Death
	Physici		LAURIE ANN MOR	GAN					Januar			5:30 P M
5	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of Death		40	. County of Death	
* -			15004 Peach Orch	ard Road				Spring			Montgomer	
	Funeral		Social Security Number 6. Si	CIN SEC		If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth Day, Year,		place (State or Foreign ntry)
	Director		221.58.3970	45	Yrs.				Sept.1	13, 1	960 Ames	, Iowa
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or L	ocation						10d. Inside City Limits
	ehov	ኳ	,									1X Yes 2 ☐ No
	788a-1	Director	Maryland Montgomo	ery S	ilver	10f. Zip				10g. Ci	itizen of What Cou	intry?
	a or		15004 Peach Orch	ard Pond			905			U	.S.A.	
	ne 23	Funeral	13004 Peach Of Ch.	12. Was Decedent Ever in U.	S. 13.			ispanic Origin? (S an, Mexican, Puert	pecify Yes or N	10-	14. Race - Ameri	
	r item	표	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, spe			o Hican, etc.)		Black, White	
8	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 LI Yes	283 NO	Specify:			Specify: WII	T.C.
2-0	be filed within 72 hours after deeth with the Maryland that Hygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, I're Medical Exarclinating the natified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece (Give	dent's Usu kind of wo	al Occup	ation during most of wor d)	king	16b. I	Kind of Business/Ir	ndustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)						٨.4	option S	ervices
7	e filed within al Hygiene. other then 'vent, Ire Me	ပိ		2 Years	Ad	optio	n co	ordinato				ervices
<u>n</u>	be fill	Be	17. Father's Name (First, Middle, Last) Charles Arvin	Foster				Doroth				
3	nould be it Mental narked o	ပ	19a. Informant's Name/Relationship (10h Mail	ing Addres	s (Street				or Town, State, Zi	in Code)
Maryland 21215-0036	12 st h and 7 ts n treun		Darren M. Morgan/									MD 20905
di.	es 1 and 2 should be of Health and Menta fitem 27 is marked r other treumatic er		20a. Method of Disposition	20b. P	Place of Disp	osition /Na	me of		Date Date		ocation - City or T	
٥	age in a second		1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	emetery, cre	matory or	otner piad	atory 2/4	1/2006	Bro	ntwood, l	Maruland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot ange.		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			2 Name a	nd Addre	ss of Facility				nalyland _
Ba	Depi Impo		Dan A	Tax Tax	\mathbf{H}	INES-	RINA	LDI FUNE	RAL HOM	E, II	NC. er Sprin	g, MD 2090
			23a. Part1. Enter the disease, or com	plications that caused the deat							OI DOLLIN	Approximate Interval Between
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	Metastatic	Bress	t Can	cer					Onset and Death 2 years
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq		c our						z years
	Examiner											
lija .		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):							
	be executed sicien and burial-transit	Examiner	that initiated events	c								
ó	exe ien ar urial-t		resulting in death) Last	Due to (or as a conseq	juence of):							
3760,	₩ × 9	lical		d								
68 x	The law requires that the death certificate alse has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	2001				-		OOA Date of deli	
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Feta	I death 3	□Ectopic p		у			23d. Date of deli Month	Day Year
0.	the a	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	ieain 5	☐ Other (s	pocity)_			-		
Δ.	s that the de ned by the a detached f	F.	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying	cause giv	ven in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?
Vital Records,	sign d be	d by							10	Yes	2⊠No 3∏Pro	obably 4 Unknown
Ö	w require been sig should b	lete							24a. W	as an	24b. Were au	topsy findings available
Re	has ge 2	Completed							ре	topsy rformed?	death?	completion of cause of
a	iician: Th certificate rector, pag	e Co	25. Was case referred to medical					26. Place of De		21 <u>k</u> N	lo 1 ☐ Yes	2 □ No
⋽	Physician: The this certificate har director, page	To Be	examiner?	Hospital:	ER/Outpati	ent 3 🗆 🗅	OA Ott	ner: 4 Nursing I			6 ☐Other (Spec	cify)
o		n H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of	28c. Inju Wo		28d. Describ			
jon	death. ctor: Aft	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		,,	М		Yes 2□No				
Division	r Atte	130	3 Suicide 6 Could not to determined			street, facto	ry, office			n (Street a Town, Sta		iral Route Number,
Ö	tel or rs aft el Dii	Certification:										
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	cal	29a. Certifier 1 ☐ Certifying P	hysician: To the best of my known or the basis of examination and magner stated.	owledge, dea	ath occurre	d at the t	me, date and plac opinion, death occ	e, and due to the urred at the tim	he causei 10, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the H within 24 To the F complete	Medical		and manner stated.				se number			Date signed (Monti	
	To To	2	29b. Signature and title of eartifier									
	12		/ /		- 00 1 =) - 332	.73		re	bruary 0	
			30. Name and address of person who Frederick P. St				n Ar-	onuo C	ite #12	ann.	Charry CL	20815
Ø.	et :		31. Date filed (Month, Day, Year)	32 Registrar's Sign				enue, su	Tre #13	,00,	onevy on	ase, FID
- *	Regist	ate trar	FEB 062	100	1. P	asile	7					

			1 - For State Registrar	State	of Maryla	nd / Depa			lealth a Death	and M	lental	Hygier Reg. N		16	048	58
			1. Decedent's Name (First, Middle,	Last)							2. Date Mont	of Death			3. Time of	Death
16.	Physic /Medi		Edward Morenof:	E								-	2, 2	2006	10:1	.0P M
	Examir		4a. Facility Name (If not institution,	give street and no	um <i>ber)</i>		4b. City,	Town, or	Location o	of Death		4	lc. Coun	ity of Death		
			6507 Tall Tree	Ter			F	Rocky	ille				Мо	ntgor	ne r v	
	Funeral			6. Sex 1 X M 2□ F	7. Age (In yrs	s. last birthday)	If Under	r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date	of Birth th, Day, Yea		9. Birth	nplace (State o	or Foreign
. 12	Director		071-28-3506		70	Yrs.		,-				2, 19			York,	NY
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation								10d. Inside Ci	ty Limite
	daryl f sho	ō													1 XYes	,
	nthe Marylana r 28a-f show motified at	Director	Maryland Mont	gomery	R	ockvi11		o Code				100.0	itizen o	f What Cou	inter?	
	th with 23a or			Ш- **			101.24		• •					· while Cou	and y:	
	death with the Maryland me 23e or 28a-f show rittust be risdilled at	Funeral	6507 Tall Tree 11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Dece	2085 dent of Hi		nin? (Spe	ecify Yes		SA 14. Ra	ace - Amer	ican Indian,	
9	after dea or iteme	F	1 ☐ Never Married 2 ☐ Marrie	Armed F	2 No	1			spanic Orig n, Mexican	, Puerto	Rican, et	C.)		ack, White		
93	72 hours after natural', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or [ive Dates: WW-	II	1 ☐ Yes	2X No	Specify:				Spec		nite	
21215-0036	72 hours after death with "naturel", or iteme 23e or "stool Everying must be	Completed	15. Decedent's (Specify only highest	Education)	16a. Dece	dent's Usu	al Occupa	ation during most	of works	na	16b.	Kind of	Business/Ir		
7	ithin	npie	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)	life.	DO NOT u	se retired)	OI WOIN	,,,,	C	ompu	iter S	Softwar	e
2	ygier ygier tr.	Co			5+	Comp	uter	Scie	ntist			~		lting	3	
PLI	be fill H doth	Be	17. Father's Name (First, Middle, L	ast)					18. Mother	r's Name	(First, N	liddle, Maide	en Suma	ime)		
Z	ould Mer Parke	2	Sam Morenoff								ne Fa					
Maryland	12 sh and ris rr		19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailir	ng Address	(Street a	and Number	r or Rura	il Route f	lumber, City	or Town	n, State, Zi	ip Code)	
e,	1 and 1ealth 9m 2		Judith Morenoft 20a. Method of Disposition	/Wife	20h	6507 Place of Dispo			e Ter		ckvi	11e,				
ō	1 = 10 8 s		1 Burial 2 Cremation			cemetery, crer	natory or o	other place	θ)	L	ate	20c.	Location	i - City or I	own, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ne any injury or other traumatic event, the Mealth once.		4 Donation 5 Other (Sp.		K	ing Dav	id Me	em Gr	dns	Feb	5, 2	2006	Fall	s Chu	ırch, V	Ά
Bal	Depa Pepa Pepa Iny it		21. Signature of uneral cervice L	censee								naldi				- 11751304
		-	1/1/0	Z					-				ver	Sprin	ng, MD	
			23a Pan. Enter the disease, or o shock, or heart failure. List o	nly one cause on	each line.			,		cardiac c	r respirat	ory arrest,			Approximate Interval Bet Onset and I	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Me	tastati	c Pancr	eatio	c Car	ncer						Onset and I I Mont	ĥ"
	Examiner		, , , , , , , , , , , , , , , , , , ,	Due to	(or as a conse	equence of);										
		-e	Sequentially list conditions,	b. — One to	(or as a conse	diverse vill										
	nsit	n in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(4										
,	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conse	iquence of):										
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.89		0		0.				-								
Вох	death certifii e attending p id for use as	Physician/M	IF FEMALE; 23b. Was decedent pregnant		tcome of pregr								23d. D	ate of deliv	rerv	
	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregi	birth 2 ☐ Fet nant at time of		Ectopic pr Other (sp							onth		'ear
0		hys	9 Unknown	9□ Unkn	nown											
D.	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant condition	s contributing to d	leath but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e.	Did tobacco	use cor	ntribute to t	the cause of d	eath?
Records,	w require been sig should b	ed k										1 🗌 Yes	2 XNo	3 🗆 Prol	bably 4 □U	Inknown
၀	s bee	Completed									24a.	Wasan	24b.	Were auto	opsy findings a	available
Re	sician: The law certificete has b rector, page 2 s	Elo										autopsy performed?		prior to co death?	ompletion of ca	ause of
Vital	an: tifice tor, p		25. Was case referred to medical					-	26. Place	of Death	Chack		0	1 🗆 Yes	2 L No	
<u>></u>	> 0 0	0	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 🗆 DC	Othe	_			Residence	6 🗆 Ot	har (Specia	64)	
	<u>o</u> = 5 e	n: T	27. Manner of Death		of Injury oth, Day Year)	28b. Time of		8c. Injury Work				ribe how inj			'97	
ō	Attending r death. ector: After by the fune	atlo	1 Pending 2 Accident S Pending investiga		in, Day rear)	Injury	м		r ′es 2 □ N	lo						
Division	il or Attend after death Director: , d in by the f	tite	3 Suicide 6 Could no 4 Homicide determin	288. Place	e of Injury - At h	home, farm, stre	et, factory	, office		2				ber or Rura	al Route Num	ber,
Ö	tal or	Certification:		bullo	ing, etc. (Opec	y /					City	r Town, Sta	(0)			
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1K Certifying (Check only 2 Medical E	Physician: To the b	e best of my kn	owledge, death	occurred	at the tim	e, date and	place, a	ind due to	the cause(s) and m	anner as s	stated.	
	the H in 24 the F iplete	Medicai	one)	and man	ner stated.	iation and/or inv	estigation,	, in my op	inion, death	n occurre	ed at the	ime, date ar	nd place	, and due to	o the cause(s)	
	Veith To T	2	29b. Signature and title of certifier	(ch		1	290	License					_		Day, Year)	
,	20		Xhurl	NE	M.	M		D018	100			Feb	ruar	y 3,	2006	
•	-		30. Name and address of person w	o completed caus												
			David J. Perry,			g St. N		shing	ton,	DC 2	20010)				
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6	2006	legistrar's Sign	lature (40)	whi									

			1 - For State of Maryland / Department	rtment of Health and I	Mental Hygier	ZHIB HUR!	59
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of E	Death
	Physici /Medio		SIMON PETER MARBLEY, Sr	•	FEB 2,	2006 Year 3:47 -	АМ
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h 4	c. County of Death	
			Holy Cross Hosipital	Silver Spri		MONTGOMERY	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1214-48-6322 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age (In yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Country) Wash. D	Foreign C
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. fnside City	/ Limits
	Aaryli eho	5		ver Spring		1 🗆 Yes	
	28a-	Director	10e. Street and Number	10f. Zip Code	10a (Ditizen of What Country?	
	Sa or	0	3122 Kilkenny Street	20904		U.S.A.	
	ms 2	Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,	
က္	or ite	Ē	1 Never Married 2 Married 1 Stres 2 No		o Rican, etc.)	Black, White, etc.	
2-0036	raf, c	l by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 67-73	☐ Yes 2 No Specify:		Specify: Black	
5-0	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give)	ent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rkina 16b.	Kind of Business/Industry	
2121	ithin	μpi	Elementary/Secondary (0-12) College (1-4or 5+)		M	ontgomery Cou	n+17
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and and	tall H	Be				in Sumame)	
Ž	2 should be and Mental is marked o	P P	DeWitt Marbley, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Address (Street and Number or Br	ah Price	vas Taum Stata Tin Cada)	
	d 2 s th an 17 is r	11	Angela N. Harris (Daughter) 27	g Address (Street and Number or Ru	Shenhe:	rdstown. WV	3
	Health tem 27 to		20a. Method of Disposition 20b. Place of Dispos	sition (Name of		Location - City or Town, State	
Baltimore,	Pages nent of ant: If it		1 SZ Buriai 2 I I Cremation 3 I I Hemoval from State	shington Cem 2			
≣	ortan			Name and Address of Facility SI			. A .
e B	permit. Pages 1 and 2 should b Department of Health and Menix Important: If Item 27 is marked any injury or other traumatic e	-		46 N. Wash. St			
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter			Approximate	
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Betw Onset and De	
Ž.	/Medical		disease or condition resulting in death) a. Artheroscler Due to (or as a consequence of):	otic Cardiovas	scular Di	sease	
н	Examiner		Sequentially list conditions b.				
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and trans	cam	that initiated events c.				
1760,	certificate be executed iding physicien and ise as the burial-transit		Due to (or as a consequence of):				
8/	physi s the b	dicai	d.				
9 ×	eath certific ettending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	eath etten for u	clan	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Ye	ear ear
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ပ္ပ	s bee	ojet			24a. Was an	24b. Were autopsy findings as	vailable
Ĭ	: The law cete has b . page 2 s	Completed			autopsy performed?		use of
		BeC	25. Was case referred to medical	26. Place of Dea	th (Check only one)	JO 10165 20110	
>	ysici nis ce direc	TO E	examiner? 1 ☐ Yes 2 ◯ No Hospital: 1 ☐ Inpatient 2 ◯ ER/Outpatient	Othor	ome 5 Residence	6 ☐Other (Specify)	
0	ng Ph Iter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
<u>0</u>	Attending Physician: If death. Sector: After this certific by the funeral director.	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			25
Division of	al or Att atter de l Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Numb lte)	er,
	To the Hospital or Attentwithin 24 hours after deating to the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death 2 Madical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)	
	A		Canolau (. Wile MD	D0061937	0	12/06	
	(W		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)		4.4	
			CANDACE L. WILSON, MD - 1500 FORES	T GLEN RD, S.	ilver Spr	INE, NO 30910)
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 0 6 2006	W			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Doreen Winifred February 2, 1:45 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 1, 1923 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 213-56-8525 82 Director Yrs. England Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location al Hygiene. other than "naturel", or Itema 23a or 28a-f ehow vent, the Medical Examinar must be multied at 10d. Inside City Limits Maryland 1 ☐ Yes 2 🖾 No Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive, #229 20906 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Representative Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental P 17 is marked of traumatic ever Pages 1 and 2 should be Samuel Farrar Winifred M. Harrison ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Heelth a portant: If Item 27 is y injury or other trains. 11135 Waterman's Drive, Reston, Virginia 20191 Dean L. May/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia permit. Departm Importar any inju 21. Signature of Funeral Service Licenses Francis Adgress Collyins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, It day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) physician s the burial Records, P.O. Box 68760 Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed res 212 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital after death.

Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2) No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or A within 24 hours after To the Funeral Directornials in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 3, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2141518CAN 1/119 Rocowin 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 6 2006 Registrar

DOREEN

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¥ '5		For	State of Maryland	d / Department of He		ental Hygi	ene 0 0 6	04861
		1 - State Registrar		Certificate of D			g. No.	
Physic	nian	Decedent's Name (First, Middle, La	st)			Date of Death Month	Day Year	3. Time of Death
/Med		GLENN RAYMOND M	OLTRUP			January	30, 2006	8:14 p [™]
Exam	iner	4a. Facility Name (If not institution, giv		4b. City, Town, or L			4c. County of Death	
		Washington Adve		Takoma P		0 D (D) 45	Montgome	
Funera		5. Social Security Number 6. S	MIN OLE		Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
Directo		200-01-1085 Usual Residence of Decedent	90			June 6,	1915 Penn	sylvania
land land		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
Many	ō	Maryland Prince	George's Hya	attsville				1 X Yes 2 ☐ No
1he	Je C	10e. Street and Number	occipe b nye	10f. Zip Code		10	g. Citizen of What Cou	intry?
illed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show ant, the Modral Examiner must be notified at	Funeral Director	7106 Adelphi Ro	ad	20782			U.S.A.	
death ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of Hist If Yes, specify Cuban,	panic Origin? (Spec	city Yes or No-	14. Race - Amer Black, White	
affer affer		1 ☐ Never Married 2 ☐ Married	1 Tyes 2 X No		Specify:	10011, 010.)		
surs ours	1 by	3 Nidowed 4 Divorced	Year or Dates:				VVII	ite
72 h	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Decedent's Usual Occupati (Give kind of work done du	ion iring most of workin	a	6b. Kind of Business/I	•
Aithin Men	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		1	Inited Stat Navy Depart	
led v tygie her t		17. Father's Name (First, Middle, Last	0	Civilian Engin	18. Mother's Name			mene —
be fi	Be						,	
should and Men should amarke	2	Stephen Andrew Me		19b. Mailing Address (Street ar	Mable Wa		City or Town, State, Z	in Code)
d2 sl th an 7 is r		David G. Moltru		22842 Welty Ch				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at		20a. Method of Disposition	20b. P	lace of Disposition (Name of	Da		20c. Location - City or	
ages nt of r. if it		1 X Burial 2 ☐ Cremation 3 [Hemoval from State	emetery, c'rematory`or other place) orge Washington Cem	1	/2006	Adelphi, M	arul and
it. P.	. 1	'4 □ Donation 5 □ Other (Special Service Lise		22. Name and Address	the same of the sa	the state of the s		
Department of the post of the		Internal	11/2				ttsville,	
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114		shock, or heart failure. List only Immediate Cause (Final	one cruse on each line.	ania Shaa	V			Approximate Interval Between Death
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te be executed ysician and he burial-transit	cal		d					
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h cert	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta				23d. Date of deli	
deat death death	Cig	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of di 9 Unknown				Month	Day Year
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OI VITA Physician: this certific ral director,	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other	4 Nursing Hon		nce 6 Other (Spec	sify)
iding Pl th. After to	 	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work	?	8d. Describe ho	w injury occurred	
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To the within 2 To the I complet	Med	29b. Signature and title of certifier	and married stated.	29c. License	number	25	9d. Date signed (Monti	n, Day, Year)
To To	-	255. Signaturo Ario Grandino	11. (1). //	IN DOC		1	1	01 1
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12		30. Na Sale address of person	co pleted cause of death (Item	2011 achimas) ain 'S.	:40 205	Silvermi	31, 2006 g,ND 2090
CHILD	tata	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	2111/6,00	11000) 01100 4411	Mrs anth
	itate strar	FED 0 7 2006	1 DE 1					

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	Physici /Medio				ELLEN I	MASTBR				Februar	y 5, 20		2:15 A	М
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п	Funeral Director		5. Social Security Number 6. Security Number 1	M 2.20 F	7. Age (In yrs. I 55	Yrs.	Months Day			8. Date of Birth (Month, Day Decembe	Yea 1 950 r 26,		place (State or For ntry) ington D	
			Usuel Residence of Decedent								1 207	Wasii	Ing con D	· C .
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation		-				10d. Inside City Lin	
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Maryland	2 sh and is m		19a. Informant's Name/Relationship (7							I Route Number				
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Bal	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licen	Davis	Smiths			l Home and 2178.	3					
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			For State Registrar		State of Ma	arylan				lealth an Death	d Mer		giene Reg. No.	006	04863	
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	within 72 hours after death with the Maryland nne. then "natural", or Items 23a or 28s-f ehow is Medical Examinar must be notified at		10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Lim	
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	h witi		410 DUTC	HMANS LANI	3			2	1639				USA	A		
	deati	Jere	11. Marital Status		2. Was Decedent	Ever in U	.S. 13.	Was Dece	dent of H	ispanic Origin In, Mexican, P	? (Specify	Yes or No)-	14. Race - Am		
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21215-0036	ours a	þ	3 ₩Widowed 4	□Divorced	If Yes, Give Year or Dates:			T Tes	2 23 NO	Specify:				Specify: W	HITE	
9	72 hc	ted		5. Decedent's Educ			16a. Dece	dent's Usu	al Occupa	ation during most of	f working		16b. Ki	nd of Business	/Industry	
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21	or th	Completed	11 YRS				SECRE	TARY					1		SERVICES	
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<u>la</u>	Ment Ment Prke arke	2	MILTON C	. JONES						EMIL	Y QU	LNN				
a	2 shc and is m	ľΫ	19a. Informant's Nan				19b. Maili	ng Addres	s (Street	and Number o	r Rural Ro	oute Numb	er, City o	r Town, State,	Zip Code)	
	and palth n 27 er tr			W. BEAVER	SON					GREE				1639		
ore	of Her	1	20a. Method of Dispo	sition [Cremation 3 □Re	moval from State	20b. P	Place of Dispo cem <i>etery, cre</i> ESAPEA	osition (Na matory or	me of other plac	(e)	Date		20c. Lo	cation - City or	Town, State	
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Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 ti eny injury or other tra ance.		21. Signature of Fun	Service License	1/0	1.				ss of Facility	non-ree	o or	umora	777 7 72	MD 21617	
m	80E 2 8		W	M. 4	11/6	-	4	00 2	. LIE	SERTY S	IKEE.	L CE	NIKE	VILLE,	MD 21017	
8760,	death certificate be executed Medical e attending physicien and d for use as the burial-transit	dical Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition and the shock of the	inal a. ditions, b. ditions b. ditions b. ditions displaying displaying c. displaying c. displaying	Due to (or as	a conseq	juence of):								Interval Between Onset and Death	>
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.O. Box	that the death certificed by the attending posterior detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 m 1 □ Yes 2 9 □ Unknown	oregnant nonths?	ic. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	I death 3	⊒Ectopic j ⊒ Other (s	pregnancy pecify)					23d. Date of de Month	elivery Day Year	
9	law requires that the as been signed by th 2 should be detache	4	Part II. Other signific	ant conditions con	ributing to death b	ut not res	ulting in the u	inderlying	cause giv	en in Part I.		23e. Did	tobacco u	ise contribute	to the cause of death?	?
sp.	uires tha signed Id be del	d by										1 🗀	Yes 2	□No 3□F	robably 4 Unkno	wn
Records,	w require been si should I	Completed										24a. Was	an	24b. Were a	utopsy findings availa	able
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Ξ		Be	25. Was case referre examiner?		ospital: 1 X Inpatio		1500		Oth	er: Place of				2 Dotter (2-	6.1	
of	Phys r this ral dia	- T	1 ☐ Yes 2 2 1		28a, Date of Inju	ILA	ER/Outpatie		0.	4 🗆 Huisi				6 □Other (Sp.	9 City)	
n	ding After fune	tion	1 Natural	5 Pending investigation	(Month, Da	y Year)	Injury	М	28c. Injur Wor	k? Yes 2 □ No			,	,		
Division of Vital	deat deat ctor: / the	Certification:	2 Accident 3 Suicide	6 Could not be	28e. Place of In	iurv - At h	ome farm st					Location (Street an	d Number or F	Rural Route Number,	_
Š	or A after Dire	erti	4 Homicide	determined	building, et	c. (Specif	(y)		.,,			City or To				
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical Co	(Check only one)	Cartifying Phys	icium To the best er: On the basis o and manner st	f examina										
	ithin the mple	Me	29b. Signature and ti	itle of certifier				25	c. Licens	e number			29d. Da	te signed (Mor	nth, Day, Year)	
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1) V V		30. Name and address		•		n 23a) (Type,		altin	none,	HO	212	01			
	M	-	Felix 31. Date filed (Month	A STATE OF THE PARTY OF THE PAR	2017c Registr			, 5								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04864 1- State Registrar Amended item #26 per dr/ wicoe/tificate of Death 02-06-2006/dls 2. Date of Death _Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Februar 1152 3 Adele Mary Mihalik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number SAUSHIM Moonico MOULS TONINSULA Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28,1909 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗷 F 96 214-10-6472 Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iteme 23s or 28e-f ehow iner roust be notified at 1 ▼ Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With 21804 400 Pacific Avenue Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status traumatic event, the Madical Examiner :-1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 X Married ö 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse <u> Health Care</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ind Mental I ပ Carl Wayne Harris Carrie Viola Pollitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7415 Parsonsburg Rd. Parsonsburg, Maryland 21849 Kaye Records/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of himportant: if ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State Hebron Cemetery 4 □ Donation 5 □ Other (Specify) 02/06/2006 Hebron, Maryland 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility Home P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approxima Imprediate Cours (Total). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 9.DKYS **Physician** /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 9 DAYS DEHYDRATION The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical as the attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No his certificete hes b il director, page 2 sl 2UNO 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tes 3 DOA 1 Inpatient 2 ER/Outpatient 4 Dursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 To the Funeral Director: After th completely filled in by the funeral within 24 hours after deat To the Funeral Director:

Maryland 21215-0036

Baltimore,

106 MILFORD STREET, SILITE 504B, SAULBURY MD 21804 NEHAL DOSH1 31. Date filed (Month, Day, Year) 32. Registrar's Signature B. Goods

M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29b. Signature and title of certified

29c. License number

63433

29d. Date signed (Month, Day, Year)

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	/Medic Examin			f not institution, give s				4b. City	, Town, or	Location of Deat		4c. County of Death					
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	p .		Usual Residence of 10a. State	Decedent 10b. County		10c City	, Town or Lo	cation							10d. Inside Cit	ny Limits	
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V	ig e e	dr jd	Elementary/Seco		College (1-4or 5	+)			use retired Maste	during most of wo.	J	Rs	ilroa	d			
7	be filed within 72 hours after death with the Marylar Hydisne. In Hydisne. In Medical Examinar must be notified at event, the Medical Examinar must be notified at		12	(First, Middle, Last)			1.1	a111	Haste	18. Mother's Nar	no /Eirst Middle						
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			23a, Part1, Boter to	e disease, or complete tailure. List only or	cations that caused	the death									Approximate Interval Bety	ween	
	Physician		Immediate Cause	(Final	Othe	- 173 C	let	-	Carl	i vs cul	And				Onset and E)eath	
	/Medical		resulting in death)	•	Due to (or as	a consequ	ience of):		٠,,,,,	D DIO CEC		~~					
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×	certifica nding ph use as th	/Me	IF FEMALE: 23b. Was deceden	t pregnant 2	3c. If yes, outcome								23d. Date	of deliv	ery		
ă	death	Physician/M	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at]Ect <i>o</i> pic] Other (pregnancy specify)				Month			/ear	
į	the cy the achec	hys	9 □ Unknown		9□ Unknown						-						
ŗ	sicien: The law requires that the death certificate be executed certificate hes been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	by P	Part II. Other signif	ficant conditions cor	tributing to death be	ut not resu	ilting in the u	ndertying	cause give	en in Part I.	23e. Did	tobacco	use contrib	ute to t	he cause of d	eath?	
	aquire en sig	ed									1	Yes 2	□No 3	□ Pro	bably 4 D	Inknown	
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<u> </u>	ing P	ü	27. Manner of Deat 1 Datural	5 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		28c. Injun Work	k?	28d. Describe	how inju	ry occurred	1			
SION	Attending in death. ector: After by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	29a Place of Init	unu - At ha	mo farm st-	M oot fact		Yes 2 □No	28f. Location	(Street a	nd Number	01 P	al Route No-	ber	
₹	5 € 5 ⊆	Certification:	4 Homicide	determined	28e. Place of Inju- building, etc	c. (Specify	')	eer, ract	лу, опісе			own, State		טו רוטו	a, noble Num	vai,	
_	To the Hospital within 24 hours (To the Funeral completely filled		29a. Certifier	1☐ Certifying Phys	sician: To the best	of my kna	wledge, death	occurre	d at the tin	ne, date and place	and due to the	e Causa(s) and mann	ner as	stated.		
	• Ho: 24 h • Fur letely	Medical	(Check only one)	2 Medical Exami		examinat)	
	To th Mithin Fo th	Me	29b. Signature and	title of certifier	1/			2	9c. Licens						Day, Year)		
	NON)T		11 /2:	Q.	1.0		0.C	.M.E.		Feb:	ruary	05	, 2006		
1	000	1	30. Name and addr	ess of person who co	mpleted cause of d	e th tem	23a) (Type,	Print)									

State Registrar

DHMH 17 Rev 1/2001

THE ODAE M. Frm.

31. Date filed (Month, Day, Year)

EER 0.7 2006

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23e, pest 2855 5/10/06 TD epartment of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30, 2006 2:05 January Do1ph McLaughlin Richard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Laure 1

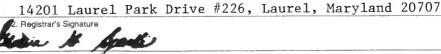
If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Laurel Regional Hospital 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 51 Yrs Nov. 21, 1954 Washington, DC Director 577-70-2698 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location rthan "naturel", or Iteme 23a or 28a-f show the Madical Examiner roust be notified at 1 Yes 2 □ No Director Maryland Prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20784 4819 70th Place Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Highway Administration, ... Pages 1 and 2 should be filed within trient of Health and Mental Hygiene. Aent: If Item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Chief of Construction State of Maryland 12 Materials Section 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred L. Chapman William R. McLaughlin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4819 70th Place, Hyattsville, MD 20784 Mildred L. McLaughlin - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Feb. 4, 2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licens is 23a. Part I. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Coronary Artery Disease disease of condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ful da a consequence of Examiner The law requires that the death certificate be executed Renal Insufficiency attending physicien and for use as the burial-tran resulting in death) Last P.O. Box 68760, Physician/Medical Pulmonary Hypertension as n IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day Year Month in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ -1-XX Yes 2XXNo 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🛛 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient ۵ 1 ☐ Yes 2 🗓 No 1 🗌 Inpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Alter Division Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident by the 1 Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 Homicide 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title January 31, 2006 D59228

cf (6)

State Registrar Elvira Pasmanik, M.D. 142
31. Date filed (Month, Day, Year)
FEB 03 2006

30. Name and add ass of person who completed cause of death (Item 23a) (Type, Print)



		For State Registrar	State	of Maryland		artment of H tificate of I		Mental Hy	giene	6 04867
		1. Decedent's Name (First, Midd	e, Last)					2. Date of De	eath Day	3. Time of Death
Physi /Med		Rober	t	Lorin	Me	arkle		Januar		M
Exam		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Deat	th	4c. County	of Death
		211 Knox S	treet			Cumbe				egany
Funera	al	5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ay, Year)	Birthplace (State or Foreign Country)
Directo	or	220-10-8893	IM ZUF	86	Yrs.			11/14/	1919	Pennsylvania
pu *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				10d. Inside City Limits
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e 23	Funeral Director	ZII K	nox Stree	E cedent Ever in U.S	S 13 1		1502	Specify Yes or No	USA 14 Bacı	e - American Indian,
iter d	Ě	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed F	orces?		Was Decedent of H f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Blac	ck, White, etc.
irs af	2		if Yes, G	ive —		1□Yes 2☒No	Specify:		Specify	White
2 hou			nt's Education		16a, Dece	ient's Usual Occup	ation	4.5-	16b. Kind of Bu	usiness/Industry
7 nic 7	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	lite.	kind of work done of OO NOT use retired	during most of wo	orking		
d with	E	12	00590	(1.15.57)	I	aborer			Tex	tile
Vent Hy	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden Sumam	10)
uld b Ment	P		Mear	kle			Vio1a		Pear1	Dunn
and le mu		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	lural Route Numb	er, City or Town,	State, Zip Code)
and and and and and and and and and and		Donna Lindner	/ friend			Knox St	reet, Cu			
Definitions, Intelligence of the 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23s or 28s-f ehow any injury or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Bemoval from	CF	lace of Dispo emetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location -	City or Town, State
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rmit.	Suc Suc Suc Suc Suc Suc Suc Suc Suc Suc	21. Signature of Funeral Service	Licensee	1	22	. Name and Addres	ss of Facility A	dams Fam	ily Fune	eral Home, P.A.
0 825	a	Kolut C.	Delen	-//		404 Decat				MD 21502
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the death each line.	n. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	ırrest,	Approximate Interval Between
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/Medica		resulting in death)	Due to	o (or as a consequ	ignce of):	- I May	1000			
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ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Fetal	death 3	Ectopic pregnancy	•			te of delivery onth Day Year
the g	100	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preq 9⊟Unk	gnant at time of de nown	eath 5	Other (specify)				
VICAL MECOLOS, T.O. BOX O sician: The law requires that the death certific certificate has been signed by the attending frector, page 2 should be detached for use as	5	Part II. Other significant condit	ons contributing to	death but not resu	Iting in the u	nderlving cause giv	en in Part I.	23e. Did	tobacco use cont	tribute to the cause of death?
w requires to been signed should be	â		1 Herel	a Acci	dan	+		1 🗆	Yes 2 □ No	3 Probably 4 □Unknown
nber negu	Completed	Co	1	0 -10	5	•		04- 146-	245	More autonou findings quallable
e law	100	Je iz wie	10150	INC CY E	1			24a. Was	psy	Were autopsy findings available prior to completion of cause of death?
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Attending r death. ector: Atte	20	Accident invest 3 ☐ Suicide 6 ☐ Could	not be 280 Plan	ce of Injury - At ho	me farm str			28f Location	(Street and Numb	per or Rural Route Number,
or A or A safter Director in by	Certification:	4 ☐ Homicide determ	nined buil	ding, etc. (Specify	<i>(</i>)	cot, ractory, omos			wn, State)	
ppitel ours nerai			ng Physician: To ti	ha hast of my know	wladoe deat	i onnumed at the fir	na. data and slan	ne, and directo the	nausa(s) and ira	annar as stated.
• Ho 24 h • Fur	Medical	(Check only 2 Medica one)	Examiner: On the							and due to the cause(s)
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, ages	₹ a	29b. Signature and title of certific	ar / /	, /	-	29c. Licens	e number		29d. Date signe	d (Month, Day, Year)
1/1			0/1/	1100	Zn.	1000	2529	(Januar	ey 30, 2006
71		30. Name and address of person	who completed ca	use of death (Item	23a) (Type,				1	
338		Stenhes?(1055 /QN	dMD	200	6/enn	St Ci	impark	and M	1) 21502
5	State	31. Date filed (Month, Day, Year		Registrar's Signal	ture		74.5	- Annah		
Regi	strar	JAN3 0	ZUUB	Meses D	S. Son	Was				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 FEBRUARY 10, 7:35 A ^M CHESTER WILLIAM METZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FRIENDSVILLE GARRETT 378 GREEN GABLES ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**)** M 2□ F Yrs. JULY 18, 1917 MD 212-03-5992 88 Director Usual Residence of Decedent 10d. Inside City Limits daath with the Maryland 10c. City, Town or Location 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
shi: if item 27 is marked other than "naturel; or items 23a or 28a-f show thy or other traumatic event, the Medical Exemples must be notified at 1 ☐ Yes 2X No Funeral Director BARTON MD ALLEGANY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23614 DOGWOOD HILL ROAD SW 21521 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: À WHITE 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CARPENTER CONSTRUCTION UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be EDITH DAWSON THOMAS I. METZ ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23614 DOGWOOD HILL ROAD SW, BARTON, MD MARY ELLEN METZ / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if any injury or gncs. BARTON, MARYLAND LAUREL HILL CEMETERY 02/13/2006 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BOAL FUNERAL HOME 21. Signature of Funeral Service Ligensee 111 CHURCH STREET, WESTERNPORT, MD 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2000 **Physician** END STAGE COPD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit To the Hospital or Attending Physicien: The law requires that tha death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year ō Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown s been signed to should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2√ No DAUGHTER'S Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence State (Specify) RESIDENCE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 💢 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 ☐ Pending investigation after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after Vithin 24 hours are To the Funeral Dir 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02/13/2006 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 WOLF ACRES DRIVE, OAKLAND, MD P. DANIEL MILLER, D.O., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 3 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of	Marylan	-	artment rtificate			ınd Men		ene () ()	6	04869
	g		1. Decedent's Name (First, Middle								Date of Death	Day 000	Year	3. Time of Death
	Physicia /Medic	al -	MARY C. MESSI								BRUARY			15:00 PM
	Examin		4a. Facility Name (If not institution			TTATT	4b. City, To		Location o			4c. County	of Death CENT	
	7		CHESTERTOWN N 5. Social Security Number		. Age (In yrs.		If Under 1		If Under 2		Date of Birth	F		place (State or Foreign
	Funeral Director		185-09-6293	1 ☐ M 2 K F	98	Yrs.		Days	Hours		Month, Day, Y	1907	Cou	mtry) MD
			Usual Residence of Decedent											
	show Let		10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 11 Yes 2 □ No
	8e-f	octo	MD KENT		KUC	K HALI		Code			100	g. Citizen of W	What Cou	
	within 72 hours after death with the Maryland ene. Than "neturel", or items 23a or 28e-f show the Medical Examihar must be notified at	Funeral Director	10e. Street and Number 21218 SHARP	STREET			10f. Zip 0	661			100	USA	vilat Cou	intry :
	ns 23	era	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Specify i, Puerto Rica	Yes or No-			ican Indian,
(0	r Iten	핊	1 ☐ Never Married 2 ☐ Marr	Armed For ied 1 ☐ Yes	2 XNo	1	If Yes, specif		n, Mexican Specify:	, Puerto Rica	n, etc.)		k, White	
ğ	ref', c	1 by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Da	tes:									
5	72 h "netu	ete	15. Deceden (Specify only highe:	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	r done d	luring most	t of working	16	6b. Kind of Bu	isiness/li	ndustry
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ф 5	filed Hygid Sther ent, 1		17. Father's Name (First, Middle,	Last)		1					rst, Middle, Ma	aiden Surnam	ю)	
<u>lan</u>	Aental Aental rked tic ev	To Be	JAMES REGIN	NALD DOWNE	Y				EMMA	"UNKNO	OWN"			
Maryland	d 2 sho th and h t7 is ma treuma	1	19a. Informant's Name/Relations CURTIS JACQUETI		LAW						HALL,			ip Code)
ē,	t Heal	1	20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Name	e of	e) 1	Date	20	Oc. Location -	City or T	own, State
E O	Page: lent o nt: If iry or		1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		state I	SLEY CE	-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		FEB.10	,2006 I	ROCK HA	ALL,	MD
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	1	21. Signature of Funeral Service	Licensee	1 de	2 1 1 m	2. Name and FELLOW 130 SP	Addres S F EER	is of Facilit HELFEI ROAD	NBEIN CHES	& NEWNA	AM FUNI	ERAL 2162	HOME, P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that co	aused the dea	th. Do not en	ter the mode	of dying	g, such as	cardiac or res	spiratory arres	st,		Approximate Interval Between
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Н	/Medical Examiner		resulting in death)	Due to (or as a consec									l
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Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):								
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о. В	the at	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregn 9☐ Unkno	ant at time of o	death 5	Other (spe	ecify)						
<u>α</u>	that the de led by the a detached f		Part II. Dther significant conditi	ons contributing to de	eath but not res	sulting in the	underlying ca	ause give	en in Part I		23e. Did toba	acco use cont	ribute to	the cause of death?
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COL	> 40	Completed									24a. Was an	24b. \	Were au	topsy findings available ompletion of cause of
Re	9 - 9	оши						_			autopsy perform	ed? (death?	2☐ No
Vital	sicien: Th certificate rector, pag	BeC	25. Was case referred to medica	ıl					26. Place		heck only one	1		
of V	Physicien: r this certific ral director,	ToE	examiner? 1 \sum Yes 2 No	Hospital: 1 □ I	npatient 2	ER/Outpatie			4 NL		5 🗆 Resider			cify)
o L	ding Pl h. After ti funera	on:	27 Manner of Death	19	of Injury h, Day Year)	28b. Time of Injury	of 28	Bc. Injun	yat! k? Yes 2□		Describe how	w injury occur	red	
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Division	l or Atten after deat Director: I in by the	Certification:	4 ☐ Homicide determ	buildi	ng, etc. (Speci	ify)	,	, 000			City or Town,	State)		
	spite hours inerel y filled		29a. Certifier Certifyi	ng Physician: To the	best of my kn	owledge, dea	th occurred a	at the tin	ne, date ar	nd place, and	due to the car	use(s) and ma	anner as	stated.
	To the Hospitel or I within 24 hours after To the Funerel Directonpletely filled in b	Medical	one)		ner stated.	attori artozor i				in occurred a				
	with To 1	2	29b. Signature and title of certifie)		29c.	Licens	e number	9.6	29	d. Date signe	Month	r, Day, rear)
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4	t)s		30. Name and address of person	who completed caus	Of Geath (Ite	111 23a) (Type	1	\$ 20	evTI	awa	MX	216	21	Q
	Sta	ite	31. Date lilled (Month, Day, Year		egista 's Sign	ature	1	32	- 1					
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1			A FOI	ent of Health and Mental Hygier	21116 1118711
	Physic		1. Decedent's Name (First, Middle, Last) Examples Co. Mova & Telia do		Day Year 3. Time of Death 2 2006 6. 42 P M
	/Medi Examii Funeral		4a. Facility Name (If not institution, give street and number) 4b. Cit University of Maryland Medical Center	y, Town, or Location of Death Baltimore	4c. County of Death N/A
161	Director		Usual Residence of Decedent 1☑M 2□F 29 Yrs. Month	ler 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Year No. 10 U. 16	416 MEXILO
	the Maryland 28e-f show	Director	10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. Street and Number	ton	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	death with the ms 23a or 28e cmunt be not	eral Dire	TACUCAL CITATION	19805	Citizen of What Country? MEXICO
5-0036	72 hours after de natural', or item	d by Funeral	1 Never Married 2 Married 1 Yes, Give 1 Was December 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes 1	edent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.) 2 No Specify: Mexican	14. Race - American Indian, Black, White, etc. Specify: MCXICAN
21215-(within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	vork done during most of working	CONS truction
Maryland	thould be filed to Mental Hygie marked other matic event,	To Be (17. Father's Name (First, Middle, Last) Roberto Morales	18. Mother's Name (First, Middle, Maio R1 + TE Je	dA
	s 1 and 2 s I Health an Item 27 is other trau		MAGA ALCARAZ/COUSIN 126		ry or Town, State, Zip Code) PAS DELAWASE 1976 Location - City or Town, State
3altimore,	permit. Page: Department of Important: If i any injury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Nicipal a/14/2006 Gu and Address of Facility	adalajara Mexico
8	Depe Impo			O-Feeley FUNEIALHOM	
	Physician /Medical		23a. Part 1. Enter the disease, for complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Complication 5 of Complication 5 of Complication 5 of Complication 6 of Complica		Approximate Interval Between Onset and Death
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O. Box 6	that the death certifica led by the ettending ph detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic 4 □ Pregnant at time of death 5 □ Other (state of the past 12 months) 9 □ Unknown		23d. Date of delivery Month Day Year
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f Vit	> W 0	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 Autient 2 ER/Outpatient 3 D	26. Place of Death Check only one OOA Other: 4 Nursing Home 5 Residence	6 ☐Other (Specify)
on of	ding Pt		27. Manner of Death 1 Natural 5 Pending Month, Day Year) 28b. Time of Injury (Month, Day Year) 110known M	28c. Injury at Work? 1 ☐ Yes 2 No Divica 1	/
Division	To the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	7 200000	and Number or Rural Route Number.
Trap.	To the Hospitel within 24 hours of the Funeral completely filled	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurre some one) 13 Certifying Physician: To the best of my knowledge, death occurre and manner stated.	d at the time, date and place, and due to the cause in, in my opinion, death occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Society of Garls my	DI HAI	Date signed (Month, Day, Year) [BMany 3, 2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 72 Sputh Greene St Baltimore	MD 21201	7
₩,	Sta Registr		30. Name and address of person who completed cause of death (item 23a) (Type, Print) 72 Sputh Greene St Bultimore 31. Date filed (Month, Day, Year) FEB 0 8 2006 Security Signature	11-00 4001	

bk for Nemto

d Mental Hygiene 0 0 6

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	State Registrar	Certificate of Death
1	For	State of Maryland / Department of Health and
7	INTCE	State of Manuand / Department of Health and

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			- Registrar				Cei	rtificate	or De	eatn		Reg. No.			
			1. Decedent's Name	e (First, Middle, La	st)						2. Date of D			V	3. Time of Death
	Physici		DOBEDT	ADAM NICE	, ID						Januar	Day 37 30	. 200	Year 76	21:35 P.M
	/Medic		4a. Facility Name (II			ber)		4b. City, To	wn, or Lo	cation of Deat		-	County o		21.00 1.
4	Examin	er		Memorial				Easto				Те	a1bot	-	
			5. Social Security N				. last birthday)			Under 24 Hrs	8. Date of B				lace (State or Foreign
	Funeral Director		217-06-	7676	X M 2□ F	35		Months I	Days H	Hours Min.	8. Date of Bi (Month, D NOV. 1	$9, \frac{Y_{\theta ar}}{19}$		MD Cour	itry)
	pug *_		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	cation						1	Od. Inside City Limits
	ehow	ō		,	t.a	am.	A GOMETT								1 ☐ Yes 2 📉 No
	Ne N 2889-1	Director	MD	QUEEN A	NNE. 2	GRA	ASONVII	10f. Zip C	ado			10a Citi	zen of W	hat Cour	stru?
	with t		10e. Street and Nur										LOIT OF TH	nat oou	шу.
	8 23	Funeral		G STORE R	12. Was Deced	tant Francis I	10 13	216		onio Origina / C	posity Voc or N	USA	M Paca	- Amoric	an Indian,
	er de	nue	11. Marital Status		Armed Ford	ces?	J.S. 13.	If Yes, specify	Cuban,	Mexican, Puer	pecify Yes or N o Rican, etc.)	0.		, White,	
36	s aft	by F	1 ☐ Never Marri	ed 2 Married	1 Tes 2 If Yes, Give Year or Da	,		1 ☐ Yes 2	No S	Specify:			Specify:	WHI	TE
21215-0036	be filed within 72 hours after deeth with the Maryland ntal Hygiene. od other then "natural", or Items 23a or 28a-f ehow event, the Madical Examitive court be notified at	Ď	3 1 THOUSE	15. Decedent's E			16a Dece	dent's Usual (Occupation	in		16b Kir	nd of Bus	siness/Inc	fustry
5	- na	Completed		ify onfy highest gra	de completed)		(Give	kind of work DO NOT use	done duri	ng most of wo	rking	700.14	10 01 000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
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ō	@ ° ± 5			☐Cremation 3 ☐	Removal from S	tate	cemetery, crei	matory or oth	er place)	1				,	
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Baltimore,	permit. Pag Depertment Important: eny injury		21. Signatur y of Fu	14.00	10	le.)6 SHAI	HEI TROCK	FENBEI	CHESTER	, MD	UNER 216	AL H	OME, P.A.
			23a. Part1. Enter the shock, or hea	ne disease, or com	plications that oa	used the dea	th. Do not en	er the mode	of dying, s	such as cardia	or respiratory	arrest,			Approximate Interval Between
	Physician	,	Immediate Cause (Final											Onset and Death
	/Medical		disease or conditio resulting in death)	n e	a Due to (c	or as a conse	carpool (complic	anna	Choled	cystecto	my			
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	ted nsit	든	if any, leading to im cause. Enter Unde Cause (Disease or	rrlying injury											
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) I		c. Due to (c	or as a conse	quence of):							-	
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ox 6	n certificate be executed anding physicien and use as the burial-transit	n/Medical	IF FEMALE:		23c. If yes, outc	ome of prear	nancy						23d. Date	of delive	an/
B			23b. Was decedent in the past 12		1 ☐ Live bit	nth 2 ☐ Fet untat time of	al death 3	Ectopic preg	nancy			-	Mon		Day Year
	at the de by the a tached i	Physicia	1 □ Yes 2 □ 9 □ Unknown	□No	9☐ Unknov		death 5	_ Out 6: (3pec							
P.0	The law requires thet the death ete hes been signed by the atte page 2 should be detached for		Part II, Other signif	icant conditions	contributing to dea	ath but not re	sulting in the u	nderlying cau	ise given i	in Part I	23e. Did	tobacco u	se contri	bute to th	ne cause of death?
Ś	res ther signed b	þ	. u.c.ii. othor organi		orning to do	2411 0 41 1101 10			go.r.		1 [Yes 2	⊠ No :	3 ☐ Prob	ably 4 🗆 Unknown
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ita	sicien: Th certificete irector, pag	Be	25. Was case refer	red to medical					26	6. Place of De	ath (Check only	one)			
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Ö	ng Ph ter th		27. Manner of Death		28a. Date of	f Injury , Day Year)	28b. Time o	f 28d	: Injury at Work?		28d. Describe	how injur	y occurre	ed	
Division	utending I death. ctor: After y the funer	atlo	1 ☐ Natural 2 Z Accident	5 Pending investigatio	1	1	UNKAOW	A.A	1 Tes	2 N No	Therepr	utic	mis	adve	iture
Vis	Atte octo by th	1	3 Suicide 4 Homicide	6 Could not be determined	289. Place (of Injury - At I	nome, farm, st		office		28f. Location	(Street and	d Numbe		I Route Number,
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	ospital or Attendous efter death hours efter death unarel Director: ily filled in by the		29a. Certifier	1 Certifying Pt			owledge, deat	h occurred at			and due to the	cause(s)	and man	ner as s	tated.
	표 2 도 음	edical	(Check only one)	2 Medical Exa	niner: On the ba: and mann		ation and/or in	vestigation, ir	n my opini	ion, death occi	urred at the time	, date and	place, a	nd due to	the cause(s)
	thin thin on the	ž	29b. Signature and	title of certifier				29c.	License ni	umber		29d. Date	e signed	(Month,	Day, Year)

		performed? death? 1 2 Yes 2 □ No 1 2 Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ∰Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 □ Natural 5 □ Pending 2 ■ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1/30/06 UNKAOWA	28c. Injury at Work? 1 Yes 2 ANO The population mis adventure								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined										

106	Cinnatura an	d title of certifier
	(Check only one)	2 Medical Examiner: On the band man
29a.	Certifier	1 ☐ Certifying Physician: To the

29b. S	ign	ature	and title	of certif	ner				
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•			1	\mathcal{M}	1		/ 1		

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZABILICIPH AZ 111 Penn

O.C.M.E. January 31, 2006 111 Penn Street, Baltimore, Maryland 21201

State Registrar

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PHYLLIS YINGLING NOWELL February 3, 2006 5:55 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 14229 Frushour Road Rocky Ridge Frederick 8. Date of Birth (Month, Day, Year) Oct. 5, 1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2√2F 87 220-20-8627 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Medical Execution results to notified at 1 ☐ Yes 2☐ No Director Maryland Frederick Rocky Ridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14229 Frushour Road 21778 U.S.A. death v Was Decedent Ever in U.S. Armed Forces? 1 ÆYes 2 □ No WWII If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Robert M. Mathias Alice Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) perriit. Pages 1 and 2 sh Department of Health and Impurtent: If item 27 is rr any injury or other treum Daniel Nowell / Son 14229 Frushour Road, Rocky Ridge, MD 21778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 2/7/06 Frederick, Maryland * 4 □ Donation 5 □ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock or hear failure. List only on ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) no/w Pirysician 97 /Medical Examiner Elm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð eq 2☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 2 10 No 1 Yes 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Pesidence 6 Other (Specify) 1 Yes 2 THO Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending To the Hospitel or Attandir within 24 hours after death. To the Funerel Director: Al М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 015804 2+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 S. Center ST Thursman 140 21788 Picker MB steven 31. Date filed (Month, Day, Year) 32. Registar's Signature State 06 2006 Registrar

			1 - For State Registrar	State of Marylan	d / Depa		t of H	ealth a	nd Mer	R	eg. No.	006	04873	3
	Physicia /Medic		1. Decedent's Name (First, Middle, La Harolyn D	. Nathan					Ja	Date of Deat Month nuary	28°,	2006 Year	3. Time of Death 9:35 a	vI
	Examin ——— Funeral	er	4a. Facility Name (If not institution, giv Southern Maryla 5. Social Security Number 6. S	nd Hospital ox 7. Age (In yrs.	last birthday)	C1:	ntor 1 Year	If Under 2		Date of Birth	Pı	cince G		
	Director		578-58-4085 Usual Residence of Decedent 10a. State 10b. County	□ M 2√xF 61	Yrs.	Months	Days	Hours	Min. No	Date of Birth Month Day, V. 9,	1944	Mon	tgomery, A	11
	the Maryla 28e-f sho	Director	Maryland Prince G		emple					1	0g. Citiz	en of What Co	12 Yes 2 Nuntry?	0
	3a or	Ī	5808 Holton Lane				2074	8			Uni	ted St	ates	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner and the natified at 900ce.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 ZiDivorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 21 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes	dent of Hi cify Cuba		in? (Specify Puerto Rica	Yes or No- an, etc.)		4. Race - Ame Black, White Specify: B1	e, etc.	
0-612	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT u	rk done a	luring most	of working		16b. Kin	d of Business/	Industry	
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2	be fill htal H od oth	Be	17. Father's Name (First, Middle, Last							rst, Middle, I	Maiden S	Sumame)		
<u> </u>	hould d Mer marke matic	To	Marshall Nathan 19a. Informant's Name/Relationship (Type Print)	19b Maili	ing Address	(Street a		h Mor		City or	Town, State, 2	in Code)	_
<u> </u>	id 2 s lith an 27 is c		Kymberla Floyd/			•				Hills,	-		_	
ก	f Hea f Hea itsm other		20a. Method of Disposition	20b. F	Place of Disponentery, cre	osition (Na	ne of		Date			ation - City or	Town, State	_
2	Page nent o int: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Hemoval from State	surrec			1	b.3,20	006	Clir	nton, M	d •	
Dalillo	permit. Departri Importe any inju		21. Signature of Funeral Service Lice			2. Name ar	nd Addres Inder Mar I	s of Facility	,		vill	es, Md:	A. ₂₀₇₄₇	
O	TO THE		23a. Part1. Enter the disease, or com shock, or heart failure. List only	pleations that caused the deal	h. Do not en	ter the mod	e of dying	g, such as c	ardiac or re	spiratory arr	est,		Approximate Interval Between	
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,007	ite be executed lysician and he burial-transit	Icai	resulting in death) Last	Due to (or as a consect	uence of):									
O. BOX OC	The law requires that the death certificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	I death 3	⊒Ectopic p ⊒ Other (s)					2	3d. Date of del Month	ivery Day Year	
us, r	uires that signed by Id be deta	d by Ph	Part II. Other significant conditions of CORONARY		_		ause give	en in Part I.					the cause of death?	٧n
records,	ysician: The law req is certificate has been director, page 2 shou	Completed by	DIABETES							24a. Was a autops perform	med?	prior to death?	itopsy findings availab completion of cause o	ele f
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DIVISION OF	nding Physath. r: After this e funeral dir	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of :	28c. Injury Work	at	28d	. Describe ho				
	To the Hospital or Attending Physician: within 24 hours affer death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	(y)					City or Town	n, State)		ural Route Number,	
	the Hosp. in 24 hou the Funei pletely fili	edicai	(Check only 2 Medicaf Exa	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or in	rvestigation	n, in my o	ointon, death	d place, and h occurred a	at the time, d	ate and	place, and due	to the cause(s)	
	To the To the comple	Σ	29b. Signature and title of certifier	• 10		1 -	D 40	324	ĺ			UARY.	18, 2-00 6	
L	(15)		30. Name and address of person who	, mo 7503	SURR.	ATTS	ROA	D, C	LINTO	N, MI	ARYL	AND	20735	
	Sta		31. Date filed (Month, Day, Year)	Registrar's Sign	lione	1								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** January 30, 2006 2:20 P. M Crossette Norrine Shelton Nesbitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 F 84 New York 076-20-8846 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits ral', or Iteme 23a or 28e-f ehow Examiner must be notified at 1XYes 2 No Maryland **Prince Georges** Fort Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 United States 1629 Tucker Road Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: **Black** ģ 3 ₩ Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Willowbrook State The Me Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide School School 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mental Hant: If item 27 le marked offury or other treumatic even Be Williams James Shelton Hattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1629 Tucker Road; Fort Washington, Maryland 20744 Joshua William Nesbitt (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb.3,2006 permit. Pege Department of Important: If eny injury or once. 5 Other (Specify) Clover Leaf Cemetery Woodbridge, New Jersey 21. Signature of Funeral Segrice Lightse R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Physician/Medical Examiner The law requires that the deeth certificate be executed 0 burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year ō in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by Sign 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2**X** No 1 Yes certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 X ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division 1 X Natural 5 Pending investigation hours after death. uneral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date, signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 100h DHS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudh V. Gupta, M.D.; 106 Irving Street, N.W.; Suite 415; Washington, DC. 20010 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 3 2006

State of Maryland / Department of Health and Mental Hygiene 06875 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 ar FEBRUARY Physician 20:14 P M GLORIA MARY ANNE O'CONNOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESRTOWN NURSING & REHABILITATION CHESTERTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. OCTOBER 12, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 1922 089-12-8900 83 NY Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h County 27 Is marked other than "natural", or Itama 23a or 28a-f show treumatic event, the Muchical Experience rough by motified at MD KENT CHESTERTOWN 1 MYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 MORGNEC ROAD 21620 USA ilad within 72 hours after deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: WHITE Ď 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mantal Is marked of JOSEPH PASCAL SARAH COLLINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dapartment of Heelth a Important: If Item 27 Is sny Injury or other tret once. 818 N. NEWKIRK ST., PHILADELPHIA, PA 19130 DEBRA F. O'CONNOR/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2006 ARLINGTON, VA ARLINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) PELLOWS HELLFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD, CHESTERTOWN, ND 21620 21. Signature of Funeral Service License HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE RENAC days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cartificata ba axecutad physiclan and s tha burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE usa 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 n onths? 4☐Pregnant at time of death 5 Other (specify) P.O. datachad 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 80 CONGESTIVE HEART PHILLIE 1 Tes 2 No 3 Probably 4 Unknown Completed HYPERTENSIVE CARDIOVASCUCAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PEMENTIA 2 No 1 ☐ Yes 25. Was case referred to medical examiner? diractor, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this funara 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Aftar Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation daath. 1 ☐ Yes 2 ☐ No tha hin 24 hours aftar daat the Funeral Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad In by 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 0 0 D0041587 Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown, MD 21620 122 Speer Rd 31. Date filed (Month, Day, Year) 32. Registrans Signature State Brance & Speck Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Req. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 9:00 a M 2006 3, February MARGARET E. OLLIVIERRE-DUFFY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 18715 North Frederick Avenue Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs. 1929 2, New Jersey 152-22-5801 76 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28e-f show other treumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Director Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23e 20879 U.S.A. 18715 North Frederick Avenue death 1 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Heatith and Mental Hygiene. nnt: If item 27 is marked other than "netural", or Iter 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 Ž No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced **Black** 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Ross Edward Ollivierre 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tree once. 1201 Smith Village Road, Silver Spring, MD 20704 Elsie Coles / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Feb. 7, 2006 Perth Amboy, NJ Alpine Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) ento Physician /Medical Due to (or a a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a corf Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 Vo
9 Unknown jo 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be del þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 3 Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 1 ☐ Yes Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 Vesidence 6 □Other (Specify) 2 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death, 4 hours after death, Funerel Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of confilier February 6, 2006 D16458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17904 Georgia Avenue #304, Olney, Maryland 20832 M.D. Thomas E. Dooley,

Registrar

31. Date filed (Month, Day, Year) FEB 0 7 2006

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			30. Name and addre	ess of person who	completed cause	e of death (Item	23a) (Type,	Print)					-		
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	Sta Registr		31. Date filed (Mont	EEB"-	1 20062	ogistar's Signat	ture #	Spen	W.						

06-00805 B.K.S DAVID JAMES OPERACZ

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ענו	OTHERS.	O1	1- State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygiei	211116	04878
	Physici /Medic		1. Decedent's Name (First, Middle, Last) David James Operacz		2. Date of Death Month FEB 1	Day Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) ROUTE # 17 @ CATOCTIN CREEK	4b. City, Town, or Location of Deat MIDDLETOWN		4c. County of Death FREDERICE	
	Funeral Director		5. Social Security Number 421-11-1553 6. Sex 1 2 F 7. Age (In yrs. last birthda)	/ If Under 1 Year If Under 24 Hrs Months Days Hours Min.		ary Coun	ace (State or Foreign try) Cance
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	death with the Maryland me 23a or 28a-f show rmust be notified at	Direct	10e. Street and Number 6730 Mt. Church Rd.	10f. Zip Code 21769	10g.	Citizen of What Coun	*
20	rs after death I', or iteme 23	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No 1989 11 Yes, Give Year or Dates: 1992	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, o	an Indian,
0500-6171	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show expiritury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) Iputer	rking 16b	engineer	lustry
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0,007,	icate be executed by physicien and burial-transit b	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
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1	7/1/1		30. Name and address of person who completed cause of death (Item 23a) (Type		eet Baltim	ore, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day Febr) 0 6 2006. Register's Signature	Spele			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** Edna P. O'Connell P٨ 27, 2006 9:40 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 1, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🙀 F 112-09-2863 87 Yrs Sept. 1918 New York Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-1 show other traumatic event, the Madical Exercitive rust be notified at 1 Yes 2 No Annapolis Maryland Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Drive, Apt. 111 21403 U.S.A. "naturel", or Itams 23e Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) parmit. Pagas 1 and 2 should be filad within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or itan any injury or other traumatic event, Ite Marical Exertation 1 Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: Specify: ρ White 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Paradis Lulu Mosier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Maryland 948 Melvin Road Barbara Hirsch/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ballimore Crematory 2/2/2006 Baltimore, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Huneral Service Lices se 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 9 aprys Adult Respiration /Medical Due to (or as a consequence of): **Examiner** Biloburel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physiclan/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 12 No 3 Probably 4 □Unknown 1 Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → Yo 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Impatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Diractor: After 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number D08314 0006185110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highung Annopalis, mn 2140/ 2 pspage 3 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2006 Registrar

			1- State of Maryland / Dep Registrar Ce	partment of Health and Mertificate of Death	lental Hygie	Z U U D -	04880
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		Barney John Parrella		January 3	31, 2006	9:40 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			Anne Arundel Medical Center	Annapolis		Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 5-23-192	9. Bir Co New	thplace (State or Foreign ountry) I York
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	f sho	5	Maryland Anne Arundel Annapoli	C			1 ☑ Yes 2 ☐ No
	28a-	Director	Maryland Anne Arundel Annapoli 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	3a or		7101 Bay Front Drive, Unit 211	21403		USA	
	ma 2	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	after or Ite		1 Never Married XXMarried Armed Forces? 1 XYes 2 No		Hican, etc.)	Black, Whit	e, etc.
င္တ	72 hours after death with the Maryland netural', or Itema 23a or 28a-f show Jissal Exeminaer must be notified at	d by	3 Widowed 4 Divorced Year or Dates: 1944-70	1 ☐ Yes 2 ☒ No Specify:		Specify: W	Mite
21215-0036	d within 72 hours after death with the Marylan jiene. r than "netural", or Itema 23a or 28a-f show It a Mudical Enaminer must be notified at	Completed	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workii DO NOT use retired)	ng 16t	o. Kind of Business	/Industry
12	within ene. than "	m	Elementary/Secondary (0-12) College (1-4or 5+)		i	U.S. Air	Force
	filed very filed very filed vent, filed ve		4 years Chie	ef Master Sargeant	(First, Middle, Maid		roice
an	D 2 0	o Be	Anthony Parrella	Anton		Benciven	ga
Maryland	2 should be and Menta is marked raumatic ev	ပ	A STATE OF THE PARTY OF THE PAR	ing Address (Street and Number or Rura	l Route Number, Ci	ity or Town, State, 2	Zip Code)
S	5 章 Z T			Bay Front Dr., Uni			
ē,	item 27		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Dimatory or other place)	ate 200	. Location - City or	Town, State
E	Pages nent of int: If its iry or o		1 VBurial 21 ICremation 31 Hemoval from State 1	on Nat'l. Cem. 2-8-	06 Ar	lington,	VA
altimore,	permit. Pages 'Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Geo	rge P. Ka	las Fune	ral Home
<u> </u>	8 9 E E 9			973 Solomons Islan			
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	terma Kalimia			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	00 7			1
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	led nsit	nine	cause. [Disease or injury]	R. L. O. L	C IN I W		11
	and al-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	- Ne Pought III	rviu		
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	dicai [Adheren				
9	g phy as th	ledic					
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of deli	,
	deat	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
<u>о</u> .	that the de led by the a detached f	Phy	9 🗆 Onknown		00 8:11		
ŝ	signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.	1 Tes	co use contribute to 210 No 3 ☐ Pro	the cause of death? obably 4 Unknown
000	w requir been si should	eted	stage III carciname stom	au v			
Sec.	e law has t	Completed			24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
					1 Yes 2	No 1 ☐ Yes	2 No
⋚	Attending Physician: r death. ector: After this certific. by the funeral director.	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: Mainpatient 2 □ ER/Outpatie	26. Place of Death	17 - 1 - 1	- 500	
o	<u>-</u> = 0	\vdash	27. Manner of D ath 28a. Date of Injury 28b. Time of	4 Nursing Hon	ne 5 Aesidence 8d. Describe how in		city)
o	ath. :: Afte	tio	1 Natural 5 Pending (Month, Ďaý Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	or Attending after death. Director: After in by the funer	iffica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (Street City or Town, St		ral Route Number,
	s after s after al Dire ed in b	Certification:	unding, etc. (Specify)		City of Town, St	ale)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or in	h occurred at the time, date and place, a	nd due to the cause	e(s) and manner as	stated. to the cause(s)
	To the within 2. To the complet	Med	and manner stated.				
	7 wit	_	29b. Signature and title of conflet	29c. License number MD 2517	290.	Date signed (Month	i, Day, Teal)
			20 Nome and address of agency who applicated account to the first		3 2	-12/06	
			30. Name and address of person who completed cause of death (Item 23a) (Type, RC5 27C7 C & MOORF Ann.	Il Mal Cala	- An	1100/10	MI
	Stat	e	31. Date filed (Month, Day, Year) Registrar's Signature		V VL-V	70 113	
	Registra		FEB 0 3 2006	We			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1125 04 2006 Joseph Pietroski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner IENINSU/a APGION of 5. Social Security Number 6 NICOMICO SACISBIN If Under 1 Year | If Under 2 Hrs. 6. Sex 1 X M 2 ☐ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours New York Director 01-06-1923 068-16-1816 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD Princess Anne Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 iteme 23a 26801 Mt. Vernon Road 21853 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 □ No

Yes Give

Year or Dates: WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No 0 Maryland 21215-0036 Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WWII White "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) el Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Pete's Body Shop none Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy importent: If tem 27 is marked othen yn julury or other traumalic event 17. Father's Name (First, Middle, Last) Be Frank Pietroski Mary Nasitka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Pietroski/Wife 26801 Mt. Vernon Road, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) Asbury U.M. Cemetery 02/07/2006 Mount Vernon, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home DDC. 11673 Somerset Avenue, Princess Anne, 1M00295MD 21853 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dan cy to **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð pege 2 should be phermonic 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan this certificete has 1□ Yes 2□No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 T.Mo 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injun 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of 29c License number

DHMH 17 Rev 1/2001

State

Registrar

M.D.

32. Regisylar's Signature

100 E.

MARUI ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V151041

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JOHN

31. Date filed (Month, Day, Year)

			For State Registrar	State of		nd / Depa	artme		lealth a	and M			2006		4882
			Decedent's Name (First, Middle, L.	ast)							2. Date of D	eath			Time of Death
	Physic /Medi	cal	George S. 4a. Facility Name (If not institution, gi	Page	nber)		4b. C	ty, Town, o	r Location	of Death	Month	40	C. County of De		1220 M
	Exami	ner	Peninsula legion		10/	onto-		501	/	-4			NICON		
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs	. last birthday)		der 1 Year	If Under	24 Hrs.	8. Date of B	irth	9. B	irthplace	(State or Foreign
	Director		295-03-3032 Usual Residence of Decedent	1,20 M 2□ F	87	Yrs.	Monti	ns Days	Hours	Min,	(Month, D			io	
	land ow		10a. State 10b. County		10c. C	ity. Town or Lo	ocation							10d. li	nside City Limits
	Ba-f eh	Director	MD Somerse	t	C	risfiel			_			10: 0			Yes 2 □ No
	with 1		10e. Street and Number				101.	Zip Code				10g. C	itizen of What (Jountry?	
	• 23	rai	26590 Marumsco		dank Francis I	10 12	Was Da		1817	ining (Co.	air. Van as N		USA 14. Race - An		dian
36	d within 72 hours after death with the Maryland Jone. If then "nature!", or iteme 23a or 28a-f ehow If a Meulcal Examinat nust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed For 177 Yes If Yes, Giv	rces? 2 ∐ No e			pecify Cuba	Specify:		ecity Yes or N Rican, etc.)	0-	Black, Wh	ite, etc.	dian,
Ş	hour turei	ed t	15. Decedent's E		ites: WWI		dent's II	sual Occup	ation			16b l	W Cind of Busines	hite	<i>u</i>
Maryland 21215-0036	within 72 ene. then "na!	Completed	(Specify only highest g	rade completed)		(Give	kind of DO NO	work done	du <i>ring</i> mos	t of worki	ng	100.1	tilla of Dasillos	a maasti	,
12	with lene.	mo	Elementary/Secondary (0-12)	College (1- none	-4or 5+)			y Mana					Hote1		
D	The House	Be C	17. Father's Name (First, Middle, Las			TIOP		, man		er's Name	(First, Middle				
lan	कू <u>क</u> कु	To B	George Clyde Page	2					Anna	abel]	le Page	2			
ΞŽ	d 2 should th and Mer ?7 is marke treumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addr	ess (Street					or Town, State,	Zip Cod	θ)
	and 2 ealth a n 27 is		Pattianne Fisher	/Daughter	r	2886	1 H	ideon	Corne	or Do	and Mr	rior	Stati	on 1	∕D 21838
ē,	ーエック		20a. Method of Disposition	Ü	20b.	Place of Dispo cemetery, crei	osition (/	vame of	OULIN		ate	20c. L	ocation - City o	r Town, S	tate
Ë	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		state	Alisbur				02/08	3/06	Sal-	isbury,	Mars	haelv
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Vice					and Addres		·		bar	isbury,	Hal	yland
	40200		23a Part1. Enter the disease, or cor	may	M00295	51	167:	Some	rset	Ave.	, Prin	cess	Anne,	MD 2	21853
	Physician		Inhediate Cause (Final disease or condition of condition for condition f	one cause on ea	ach line.	A	ter the m		discon as			arrest,		Inte	rval Between et and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):									
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oʻ	ate be executed hysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (d	or as a conse	quence of):									
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α.	that the	Ph)	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlyin	cause givi	en in Part I.		23e. Did	tobacco	use contribute	to the car	use of death?
rds	w requires that been signed should be del	ed b)									1 🗆	Yes 2	□No 3□F	robably	4 Unknown
Vital Records,	ne law re s has be ge 2 sho	Completed										psy ormed?	prior to death?	complet	ndings available ion of cause of
a			25. Was case referred to medical						OC Disease	- d Dansh	1 Yes		1 ∐Ye	s 2	No
⋚		o Be	examiner?	Hospital:	patient 2]ER/Outpatier	. 2	Oth	25		(Check only		6 Florber (Ce		
ō	Phys r this sral di	2	27. Manner of Death	28a. Date o	f Injury	28b. Time of		DUA			ne 5∟ Hes 28d. Describe		6 □Other (Sp	ecity)	
on	th. Afte	ig	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	n, Day Year)	Injury	М	28c. Injun Worl	<br Yes 2 □ I						
Division of	of after death. I Director: After	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place	of Injury - At h g, etc. (Speci	nome, farm, str	eet, fact	ory, office		2	28f. Location City or To		nd Number or F e)	Ru <i>rai R</i> ou	ite Number,
	To the Hospital or Attending Phy within 24 hours atter death. To the Funerel Director: After this completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the miner: On the ba and mann	sis of examina	owledge, death ation and/or in	n occurr vestigati	ed at the tim on, in my of	ne, date an pinion, dea	id place, a th occurre	and due to the	cause(s date an) and manner a d place, and du	is stated.	cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1/-			1	9c. License	number			29d. Da	ite signed (Mor	nth, Day,	Year)
	- > - 0		> K E	Kyru	1			NZ	400	7			2_/	2/-	
•			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type	Print)	בעג	180.	/		2	1-6-0	0	
			Panech Aganos	I IM F	(nor	11/54		8/1/5	hur	N	0 21	801			
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	Registi		FEB 0 8	3 2006	Francis	W	1								

			1 - For State Registrar	State of N	larylan		artmen rtificate					giene Reg. No.	006) 4 (383
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2	2. Date of Dea Month	ath Day	Year		e of Death
	/Medic		Georgia Powell					.			Februa		2006		30 ^M
7	Examir	ner	4a. Facility Name (If not institution,						Location	of Death			County of De		
	Eunaval		McCready Memor 5. Social Security Number			last birthday)	If Under		If Under		B. Date of Birt	h	omerse	et irthplace (Sta Country)	te or Foreign
	Funeral Director		214-74-7554	1□ M 2 F	95	Yrs.	Months	Days	Hours	Min.	(Month, Day 0 / 24 / 1	y, Year)		Country)	
	р ,		Usual Residence of Decedent		,						W, Z=+, 1	710			- City Limite
	shov	ž	10a. State 10b. County		TUC. CIE	y, Town or Lo	cation								e City Limits
	the M	Director	MD Somer 10e. Street and Number	set	Pr	incess	Anne 10f. Zip	Code				10a Citis	zen of What 0	Country?	
	with Be or	2		Charach Day	1		101. 210		1050			rog. Onia		,	
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12	within iene. than	J L	Elementary/Secondary (0-12) Q	College (1-4o	5+)	Homen			,			0	Home		
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lan	2 sho and is my		19a. Informant's Name/Relationshi				_				Route Numbe	-			
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Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State	• C	emetery, crer	natory or ot	ther place							
를		1	' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Ве	echwoo				2/05/	2006	Prin	cess A	nne, M	D
Ba	permit. Departr Importe any Inji	(- ann Lolys	. ()	295		. Name and .nman				Destant		A	ND 010	F 2
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	Pnysician	ar a	Immediate Cause (Final isease or condition	/2/	neu		~ie							Onset a	nd Death
	/Medical Examiner		resulting in death)	Due to (or a											
	Examine	<u>.</u>	Sequentially list conditions,	b. — Due to (or a	1 A ACCASO	usean offi-								-	W.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20 01 01 00	a a consequ	delice or,									
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9	ertifica ing ph e as th	Med	IF FEMALE:											ļ	
Вох	eath certific attending p for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	Ideath 3□	Ectopic pre					2	3d. Date of de Month	elivery Day	Year
<u>o</u> .	that the de led by the a detached f	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant : 9□Unknown	at time of di	eatn 5∟	Other (spe	эспу)							
፲	that the poly of t		Part II. Other significant condition	s contributing to death	but not resi	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribute	to the cause	of death?
Vital Records	law requires as been sign 2 should be	ed by									1 🗆 Y	es 2 🗹	3No 3□F	Probably 4	∐Unknown
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	After After fune	tlon	1 Natural 5 Pending 2 Accident Investiga	(Month, D	ay Year)	Injury	M	Bc. Injury Work 1 □ Y	? ′es 2.⊟≀		d. Describe ii	OW INJURY	Occurred		
Division	l or Attending after death. Director: After I in by the fune	Ifica	3 Suicide 6 Could no	t be 28e. Place of Ir	ijury - At ho	me, farm, str	eet, factory,	office		281	f. Location (S	treet and	Number or F	Rural Route N	umber,
á	s after s after ol Dire	Certification:	4 Homicide	building, e	tc. (Specify	/)					City or Tow	n, State)			
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medicel E:	Physicien: To the bes keminer: On the basis and manner s	of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, and th occurred	d due to the o at the time, o	ause(s) a date and	and manner a place, and du	as stated. ue to the caus	e(s)
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}			Som				1 3) 57	44	22		te	b./7	106	
			30. Name and address of person w Sarad Baral,	•			•	Poss	moles	Ci+	MD 3.	1251			
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	Registr	- 00	FEB 0	8 2006	Meser.	H.	bare	رو							

JEAN M. PAUL 06-00838 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

D			1 - For State Registrar	State of M	arylar	•		nt of H		and M		giene Reg. No.	006	048	84
			1. Decedent's Name (First, Middle, Las	<i>(t)</i>							2. Date of De Month	ath Day	Year	3. Time of	Death
	Physici /Medio		Jean Michel	Paul							FEBRUA	RY 3,	2006	1:25A	м.
1	Examir		4a. Facility Name (If not institution, give HOWARD COUNTY GEN	ERAL HOSP	ITAL		COL	, Town, or UMBIA				НС	WARD		
	Funeral Director		213-94-2751	9X 7. Ag S M 2□F	ge (In yrs. 49	last birthday) Yrs.	Months	or 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 2/16/	1956	9. Bi	nthplace (State of country) Haiti	ir Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ity Limits
	Mary 11 sh	ţō	Md. Howard	F		Columb	ia							1 🗆 Yes	2 No
	h the	lrec	10e. Street and Number					ip Code				10g. Citiz	en of What C	ountry?	
	23°	ral	10288 Nightmist	Ct.				210					USA		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heelih and Mental Hygiene. Item 27 ie marked other then "neturel", or Iteme 23e or 28e-f ehow other treumatic event, the Medical Exeminer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married	12. Was Decedent Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates:	?			edent of His ecify Cubar 2 No	spanic Origin, Mexican Specify:	gin? (Spe n, Puerto f	crly Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify: B		
5-0	"netu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	kind of w	ual Occupa ork done d use retired)	uring most	t of worki	ng	16b. Kin	d of Busines:	s/Industry	
121	within Bne. then	dwo	Elementary/Secondary (0-12) 12yrs	College (1-4or	5+)			nance		ervis	or		mainte	enance	
d 2	filed Hygid other	BeC	17. Father's Name (First, Middle, Last)			1.2					(First, Middle,				
/lan	2 should be filed withlic and Mental Hygiene. Ie marked other then eumatic event, the Me	To B	Hugues A. Paul							Jea	nette	Perc	У		
, Maryland 21215-0036	1 and 2 sho Heelth and I tem 27 ie mu		19a. Informant's Name/Relationship (7 Evelyn X. Paul/w.								Columb				
Baltimore,	permit. Pages 1 and of Department of Heelth Important: If Item 27 eny injury or other troops.		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐	Removal from State	0	Place of Dispo cemetery, cren	natory or	other place			ate			r Town, State	
ţ	permit. Pages Depertment of I Important: If It eny Injury or o		4 □ Donation 5 □ Other (Specify)	Go	od She					./2006			City,Md. Lly F.H.	
Bal	permit. Departn Imports eny ink		21. Signature of Funeral Service Licen	mato	MOO									y,Md.21	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that cause one cause on each li	d the deat ine.	h. Do not ente	er the mo	ede of dying	, such as	cardiac o	r respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dula to (or as	a conseq	uence of):									
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387	cate t physics the t	dical	•	d											
.O. Box 6	at the death certificate be executed by the attending physicien and teched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic Other (pregnancy specify)				2:	3d. Date of de Month		Year
٦.	es that the igned by be detec		Part II. Other significant conditions of	ontributing to death b	out not res	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did t	obacco us	e contribute	to the cause of d	leath?
ords	v require been sig should by	ed b									10	res 2□	No 3∏F	robably 100	Jnknown
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J o	Physiclen: this certific ral director,	ဥ	1 X Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpatio		ER/Outpatien			4 🗆 Nu		ne 5 Resid			ecify)	
o	Alter fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	fnjury	м	28c. Injury Work 1 🔲 Y	at ? ′es 2∐!		28d. Describe I	iow arjury	occurred		
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_	Hospita 4 hours Funerel	Medical C		ysician: To the best iner: On the basis of and manner st	f exa <i>m</i> ina										;)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	1	1	,	2	9c. License	number			29d. Date	signed (Mon	ith, Day, Year)	
			• 4	M. 2	1			0.C.	M.E.			FEBRU	ARY 3,	2006	
2)1	2		30. Name and address of person who	-	death (Iten	n 23a) (Type,	Print) 111	DEVIN	CTDI	ם יויקי	AT TTMO	RE M	ΔΡΥΤ ΔΝ	D 21201	
4			JACK M. J 31. Date filed (Month, Day, Year)	32. Redistr	ar's Sinns	iture	TTT	L CTAIN	PIKE	ם דמוכ		الل ونلد	CAL T LIAI		
*	Sta Registr				ear s Signa		bons	20							

		,	1 - For Stata Registrar	State of Maryland	/ Department of Certificate			giene	04885
1	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last) FONCES 4a. Facility Name (If not institution, give s	Phillips treet and number) soital Cent	46. City, Tow	rk m, or Location of Deal testown	2. Date of Dea Month	29 2006 4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 215-44-6753	7. Age (In yrs. las	st birthday) If Under TY Yrs. Months D	ear If Under 24 Hrs ays Hours Min	(Month, Day	9. Birth Co. / 1945 MD	place (State or Foreign intry)
	Maryland a-f show	ctor	10a. State 10b. County MD Queen A		Town or Location lington				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, it e Medical Exaniter must be notified at	by Funeral Director	10e. Street and Number 104 Kirby's Lar 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ading Road 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wo If Yes, Give Year or Dates:	10f. Zip Co 2165 13. Was Decedent If Yes, specify 1 □ Yes 2 🔀	of Hispanic Origin? (S Cuban, Mexican, Puer		USA 14. Race - Amer Black, White Specify: Wh	ican Indian, , etc.
21215-0036	within 72 hou ene. than natura	Completed	15. Decedent's Educ (Specify only highest grade	ation	life. DO NOT use n	one during most of wo stired)	rking	16b. Kind of Business/l	
land 21	ould be filed w Mental Hygier arkad othar th atic evant, the	To Be Cor	12 17. Father's Name (First, Middle, Last) William Clayton		Teacher	18. Mother's Na	me (First, Middle, beth Ba	Educat Maiden Sumame) xter	ion
, Maryland	1 and 2 should be Health and Mental am 27 is markad thar traumatic ev		19a. Informant's Name/Relationship (Type James E. Quirk/		19b. Mailing Address (St 104 Kirby			r, City or Town, State, Zi illington	
Baltimore,	permit. Pages 1 a Department of He important: If itam any injury or oths		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □Ri 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State CHE	ce of Disposition (Name of netery, crematory or other ISAPEAKE mation Ceres 22. Name and A Fellows	nter 02/	- 1	20c. Location - City or 1 5 Chester, Newnam Fu	
,	Fnysician Medical Examiner		23a. Cart 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	EAST CAN				Approximate Interval Between Onset and Death
8760,	death certificate be executed a attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
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rds, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions con	ributing to death but not result	ing in the underlying caus	e given in Part I.	23e. Did to	bacco use contribute to les 2 No 3 Pro	the cause of death?
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/ita	ician: Th certificate rector, pag	Be	25. Was case referred 6 medical examiner?				ath (Check only o	ne)	
of	hys this al dii	T.	1 Yes 2 No		R/Outpatient 3 DOA	-		ence 6 Other (Specow injury occurred	ify)
Division	tending death. tor: After the fune	Certification:	1 Atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom	М	Injury at Work? 1 Yes 2 No		treet and Number or Ru	ral Route Number,
Dİ	spital or lours afte naral Dire	ai Certi	29a. Certifier 1 Certifying Phys	building, etc. (Specify) icien: To the best of my knowl	ledge, death occurred at the	ne time, date and plac	City or Tow	ause(s) and manner as	stated.
	ha Ho in 24 h ha Fu pletely	edical	(Check only 2 Medicel Examinate)	er: On the basis of examinatio and manner stated.	on and/or investigation, in	my opinion, death occ	urred at the time, o	dato and place, and due	to the cause(s)
	To tha h within 24 To tha F complete	M	29b. Signature and title of Contifier	Jahn me	3 29c. Li	36.05	4	29d. Date signed (Month	Dey, Year)
2	O) 5		30. Name and address of person who co		23a) (Type, Print)	Rd, CHE	Deron.	n Md Z	620
	Sta Registr		31. Date filed (Month, Pay, Year).	2006 32. Registrar's Signatur	re A Angell	<i>-</i>			

State of Maryland / Department of Health and Mental Hygiene 04886 Certificate of Death Reg. No 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Waltraud Rogal1 February 2006 4:00 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Vrs 578-54-0630 Feb. 24, 1940 Germany Director 65 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28e-f show may injury or other treumatic event, the Mardical Examinating or other treumatic event, the Mardical Examination or other treumatic event, the Mardical Examination or other treumatic event. 1 ☐ Yes 2X ☐ No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 3200 Leisure World Blvd., N., #914 Germany 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Specify: þ 3 Widowed 4 Noivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Orthodontic Laboratory Owner/Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilhelm Walter Wenzel Else Brunne 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise K. Rogall/Daughter 7204 Mill Run Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 3, 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 2006 Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee... dan MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TASTATIC Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury ue to (or as a consequence of) Examiner as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SCLE 21210 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 2 1 Inpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 1 Avatural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Pl 124 hours after death.
 Funerel Director: After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. To the I 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Rem 23a) (Type, Print) (ROSE WD. 0121

Registrar

State

31. Date filed (Month, Day, Year)

FEB

0 6 2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day LOUISE C. RIGGAN Physician February 5, 2006 2:15a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. 28, Date of Birth (Month, Day, Year) Jan. 28, 1917 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖺 F 215-44-8630 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r then "neturel", or items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20904 USA 11605 Lockwood Drive, #204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: White filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Completed by 3 Widowed 4 NDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business/Industry during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Office Administrator permit. Pages 1 and 2 should be filed w Department of Heelth and Mental hygies Important: if item 27 is marked other then rely injury or other treumatic event, the ODE. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Zelia Elizabeth Nunnally Charles Boyd Chase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra M. Burn/Personal Representative 204 Northbrook Way, Greenville, South Carolina 29615 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory February 5,2006Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc 21. Signature of Funeral Service Licengee Sumper Value 500 University Ballewill, New Affect Spring, Mary and USC Approximate Interval Between Onset and Death 23d. Part1. Enter the disease, of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonan Physician Days /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown should b hypertension 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Chronic Obstructive Pulmonary disease 2 No certificate 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 25No 2 After this c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide the Hospitei To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier tebruary 2006 D61067 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAURA KHANDAGLE 831 University BLVD East Suite 25 Silver Spring Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year) **LEB U 8 5008** Registrar

DHMH 17 Rev 1/2001

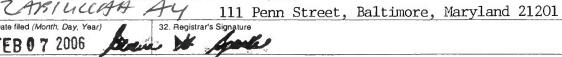
Registrar

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	Funeral Director		579-08-9011	6. Sex 1√2 M 2□		(In yrs. I 21	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of E (Month, 8	Birth Day, Year	9.	Birthplace (State or Foreign Country) D.C.
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	with the sa or 28a I be noti	i Director	10e. Street and Number #14 Gallatin S	t. N.W					p Code 20011				10g. C	itizen of What	
350	be filed within 72 hours after death with the Maryland ital Hygiene. do other then "natural", or itams 23a or 28a-f show event, I'm Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was I	Decedent E d Forces? (es 2 %) No s, Give or Dates:		1	Vas Dece f Yes, spe 1 ☐ Yes	cify Cuba	ispanic Or an, Mexical Specify:	n, Puerto	ecify Yes or ! Rican, etc.)	No-	Black, W	merican Indian, /hite, etc. Black
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/land	e = 0 >	To Be C	17. Father's Name (First, Middle, L Warren A. Roy	ast)			F-143, 53	• •				E L. C		-	
Mar.	as 1 end 2 should to of Heelth and Ment (Item 27 is marked rother traumatic		19a. Informant's Name/Relationsh Warren A. Roy-											or Town, Stat	e, <i>Zip Code)</i> C. 20011
baitimore,	permit. Peges 1 of Depertment of He Important: If Item any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		rom State	CE	lace of Dispo emetery, cren sh. Na	natory or	other plac	ery	2-7-		St	uitland	•
Dall	permit. Depertr Importa		21. Signature of Funeral Service L	icensee	un					ss of Facili		Bonnet W., WD			Funeral Hom
)	Physician /Medical Examiner		23a. Part. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aDue	on each fine).	n. Do not enter			g, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death
,09/89	ate be executed thysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a										
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<u>,</u>	sign d be	þ	Part II. Other significant condition	ns contributing	to death but	not resu	ulting in the ur	nderlying	cause give	en in Part I				^	e to the cause of death? Probably 4 Unknown
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 288. P	uilding, etc.	(Specify	str	111			14	1810 F10	hel P	ark Rd.	Prive, George's
	ne Hosp n 24 hou ne Funa sletely fil	Medicai	29a. Certifier (Check only one) 1 Certifying Wedical E	Physicien: To xaminer: On the and r	the best of ne basis of e manner state	xaminat	wledge, death lion and/or inv	occurred estigation	dat the tim	ne, date ar pinion, dea	nd place, and place, and place in the place	and due to the	e cause(: e, date ar	s) and manner nd place, and r	r as stated. due to the cause(s)
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4	ye		30. Name and address of person w	no completed	cause of de	ath (Item	23а) (Туре,			.,					, ====

State Registrar

31. Date filed (Month, Day, Year) FEB 0 7 2006



			1 - For State Registrar	State of Mai	•	artment of H	lealth and	•	giene	01,891
					Ce	rtificate of	Death	2. Date of Dea	Reg. No. UU	3. Time of Death
п	Physici	an	1. Decedent's Name (First, Middle, La		2			Month	Day Year	8:30 PM
	/Medic	al	James Osc 4a. Facility Name (If not institution, giv		er, Jr.	4b. City, Town, o	r Location of Dea	Februar	y 4, 2006 4c. County of Dea	
	Examin	ier	4845 Mary Lane	o street ale number,		White P		••••	Charles	
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hr		h 9 Birt	thplace (State or Foreign
	Director		234-46-8008	(X M 2□ F	69 Yrs.	Months Days	Hours Mir	Oct. 27	, 1936 West	t Virginia
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	death	Funeral	4845 Mary Lane 11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H		Specify Yes or No-		
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ဗ္ဗ	within 72 hours efter death with the Maryland ene. then "netural", or items 23a or 28e-f ehow the Medical Examiner man be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1960-62					
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12	withir ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+))	uter Inst	,		Computers	
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an	fental rked ric ev	ToB	James Oscar Rise	er, Sr.			Pearl	Ellen F	rench	
Maryland 21215-0036	and N		19a. Informant's Name/Relationship (Type, Print)		•			er, City or Town, State.	Zip Code)
Σ	and and a selth n 27 i		Brancie Jane Rise	r - Wife	+		e, White		MD 20695	
ore	Jes 1 of Ho Il iter		20a. Method of Disposition 1X Burial 2 Cremation 3	Removal from State		matory or other plac		Date	20c. Location - City or	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Deperment of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "neturat; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at one.		21. Signature of Funeral Service Licer	Sil con Mi	M/7h	2. Name and Addre Huntt Fun	-		01d Washing rf, MD 2060	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	he death. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
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89	ng ph	Med	IF FEMALE:							
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<u>ڪ</u>	after after i Dire	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	1001, 1401017, 011100		City or Tov	vn, State)	
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(30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)	<u> </u>			-
_	DD51		Daniel Howell, MC			Waldorf,	MD 2060	02		
	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar	's Signature					
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 2, 2006 5:54P M Elizabeth Ann Reed /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville <u>Shady Grove Adventist Hospital</u> | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 7, 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 217-32-4485 68 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 No Damascus Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or items 23a or 20872 U.S.A. 24408 Club View Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced "natursi', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National Lutheran e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Food Preparation 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itsm 27 ie marked other any njury or other treumatic event. 17. Father's Name (First, Middle, Last) Mary Sullivan James Calvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24408 Club View Drive, Damascus, Maryland 20872 Margaret B. Stone - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2/6/06 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sture of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 FI KNI /Medical Due to (or as a consequence of). Examiner Due to (or as a consequence of): v010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and hed for use as the burial-transit The law requires that the deeth certificate be executed Cordial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 2/2/20 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 0/9 autopsy performed? res 2 No 1 ☐ Yes 2 → certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 patient 2 ER/Outpatient 3□ DOA 28a. D te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death.

| Director: After in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 5 DAILES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dactors Drive 19529 6 2006 Registrar

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	/Medi Examir		4a. Facility Name (If not institution,						Location of D		A1 1 CANA		County of De		
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Maryland	2 should and Men ie marke	၉	19a. Informant's Name/Relationsh				-			or Rural R			or Town, State)
	s 1 and 2 should be filed within 72 hours after deeth with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f ehow other treumatic event, Ira Medical Examiner must be notified at		Penelope E. Lo	gsdon / nie	ce	1717	Bed	ford	Street	t, Cu	mberl	and,	MD 2	1502	
Jre,	of Height		20a. Method of Disposition	2	20b. F	Place of Disposi cemetery, crema				Date			ocation - City o	or Town, S	tate
Ē	nit. Pege entment o cortant: if injury or		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		e	se Hill			1	/30/	2006	Cu	mberla	nd, N	1D
Baltimore,	permit. Peges 1 and Depertment of Health Important: if item 27 eny injury or other tr once.		21. Signature of Funeral Service L	icensee											ne, P.A.
	70E 2 9		Kolut C.	/delin	2								nd, MD	1	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caus only one cause on each	id the deat line.					rdiac or re	spiratory a	rrest,		Appr Inter Onse	oximate val Between et and Death
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	_a USPI	rati		neu	TWO	mia						
	Examiner		an an an an an an an an an an an an an a	Due to (or a	_	1 1	10	0.1	m 0000	T	Disea	CA			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chronic Due to (or a			/C_	JUI	monar	4 1.	العادرات	-SC			
	ate be executed hysicien and he burial-transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events												
oʻ	e be executed rsicien and e burial-transit	Ex	resulting in death) Last	Due to (or a	s a conseq	uence of):									
8760,	ate by hysic the bu	licai		d											
89 x	ertific ding p	Med	IF FEMALE:	23c. If yes, outcom	o of progn										
Вох	leath certificate ettending phy I for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	I death 3 ☐E	Ectopic p	regnancy				1	23d. Date of d Month	elivery Day	Year
P.O.	the d y the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	21 11110 01 2		O (1101 (3)	poony)		1/-					
	uires that the de signed by the e Id be detached f	y P	Part II. Other significant condition	s contributing to death	but not res	ulting in the unc	derlying o	cause give	en in Part I.		23e. Did t	obacco u	ise contribute	to the cau	se of death?
Records,	w require: been sig should b	Completed by	Congestive He	art Failur	e					_	10	Yes 2	□ No 3 🖪	robably	4 Unknown
ဝ၁	ie law requ hes been je 2 shouli	plet									24a. Was		24b. Were a	autopsy fir	ndings available on of cause of
Œ	The ete h	Com									perfo	rmed? 2 No	death?	s 201	
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Harrison d				100	26. Place of	Death (C	heck only o	one)			
of \	Physi this o	2	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital:		ER/Outpatient 28b. Time of	3 D		4 Nursir				6 □Other (Sp	ecify)	
u C	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending		ay Year)	Injury	м	28c. Injury Work	γaι (? Yes 2∐No		. Describe !	now injur	y occurred		
Division of Vital	deat deat ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of I	njury - At ho	ome, farm, stree							d Number or I	Rural Rou	te Number,
á	after after of in b	ert	4 Homicide determin	building,	etc. (Specil	y)					City or Tox	wn, State)		
	To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying	Physician: To the bes	t of my kno	wledge, death o	occurred	at the tim	ne, date and p	lace, and	due to the	cause(s)	and manner	as stated.	auga(s)
	in 24 in 24 in Fi	Medicai	one) 2 Medical E	xaminer: On the basis and manner:	or examina stated.	tion and/or inve				occurred a					
	To To mos	2	29b. Signature and title of certifier	COR '	/	1	29	c. License				29d. Dat	te signed (Moi	nth, Day, ነ	Year)
	6		flewer you	OKR.		~)		D5	4411			Jane	2 pract	7, 20	006
	nes		30. Name and address of person w		0.5	MOTIC	rint	00.10	Sui	10.	nc. 1	11100	horlan	dmi	77197
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signa		· 1 //	CIIUK	201	161	ادں	LUIY	noci (III)	U) 11	المال المال
	Registr		JAN 3 0 20	106	20 1	1. 600									

	-	For State Registrar	State of Marylar		artment of H rtificate of I			ene () ()	6 04894
Physician	n	1. Decedent's Name (First, Middle, Last)	Ross.	51.			2. Date of Death Month	1	Year // 3 6 MM
/Medica Examine Funeral	er e.	5. Social Security Number 6. Sex	etreet and number) PA HOSP / 7. Age (In yrs.	ta /	Be 1	Location of Death	8 Date of Birth		Death Color for Service of Foreign
Director		058 14 5965	M 2□F 83	Yrs.	Months Days	Hours Min.	(Month, Day, 3 / 11	/ 22	New York
Maryland a-f show	tor	10a. State 10b. County MD Worcester		ty, Town or Lo	ocation				10d. Inside City Limits 1 Yes 2 No
uth with the M 23e or 28e-f	Direc	10e. Street and Number 9715 Healthway Dr	ive		10f. Zip Code 2181			og. Citizen of Wh	nat Country?
1215-0036 within 72 hours after death with the Maryland ene. then "natural; or items 23s or 28s-f show he Medical Esseminer must be notified at	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Ever in U Armed Forces? 1√2 Yes 2 □ No WW 1⁄4 Yes, Give Year or Dates: 1944-	/11	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sin, Mexican, Puerle Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc. White
21215-0036 ad within 72 hours alt gjene. or then 'naturel', or the Medical Exami	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired attern Ma	during most of wor.)	king	6b. Kind of Bus	
Maryland of the should be tile the and Mental Hyg 77 is marked other traumatic event.	To Be C	17. Father's Name (First, Middle, Last) Daniel Ross				Nora O	ne (First, Middle, M		
Baltimore, Maryland 21215-003 permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: if item 27 is marked other then "naturel", any injury or other traumatic event, tra Medical Exagnica.		19a. Informant's Name/Relationship (Ty, John J. Ross, Jr. 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	20b. I	1140 Place of Dispo	O Coastal Sition (Name of natory or other place nlopen Ci	Hwy. #	1-C Oce	ean City	MD 21842 ity or Town, State
Baltin permit. P Departme Importan any injury		21. Signaturer Funeral Service License		22	2. Name and Address urbage Fi	s of Facility	108	William	rd, Delaware St. 21811
1972 AddC 18760, cate be executed physician and ithe burial-transit	dical Examiner	23a. Part1. Error the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect SIGMO). Due to (or as a consect SIGMO). Due to (or as a consect SIGMO).	quence of): 15C quence of):	hemia Olvulu		or respiratory arre	st,	Approximate Interval Between Onset and Death Onset Aug S
3/11/ Box 6 death certifi	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
Record e law requirements been s	Completed by Pr	Part II. Other significant conditions con Coronary Ori Africal fibrilla	heroscle	I I	heat	en in Part I. USEA	1 ☐ Yes 24a. Was an autopsy perform	s 2 No 3	oute to the cause of death? Probably 4 @Unknown ere autopsy findings available or to completion of cause of ath? J Yes 2 \(\sigma \) No
of Vita hysicien his certifi	0 00	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 4 impatient 2	ER/Outpatier	at 3 DOA Othe	er: 4 🗆 Nursing H	ome 5☐ Resider	nce 6 Other	
After After	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury ome, farm, str	M 1 \(\text{'\text{Vort}}	rat ?? Yes 2 □ No	28d. Describe how 28f. Location (Str. City or Town,	eet and Number	or Rural Route Number,
Division To the Hospitel or Attenwithin 24 hours after deal to the Funeral Director: Completely filled in by the	edical	(Check only 2 Medical Examile one)	icien: To the best of my known and manner stated.	owledge, death ation and/or in	vestigation, in my op	pinion, death occur	rred at the time, da	te and place, an	d due to the cause(s)
Tot with To Ton		29b. Signature and title of certifier **Eusture 2 30. Name and address of person who co	Suffin mpleted cause of death lites	, MO	29c. License	000679	5	2-4-0	(Month, Day, Year)
ET 1+1 State	е	KRISTINE GRING 31. Date filed (Month, Day, Year)		09 4	DASTAL	HI6HU	UAY, FE	FNUC	KISLAND, PE

				For Amend Item 26 Registrar	State of Maryland per verb., G85						04895
		Physici /Medic		Decedent's Name (First, Middle, Last) RUTH LORRAINE ROWLEY						ath Day 200	3. Time of Death 2208 M
•	7	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat Upper Chesapeake Medical Center Bel Air				Air		/4c. County of Dea Harfo	rā
	r de	Funeral Director		EIG EG GG	7. Age (In yrs. las	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 9/21/1	y Year) 9. Bi 931 Mai	nthplace (State or Foreign ountry) Cylanc
3	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Exans are must be addited at 2008.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Harfcrd	-	Town or Loc White					10d. Inside City Limits 1 ☐ Yes 2 X No
# 5				10e. Street and Number 1213 Old Pylesvil	1e Road		10f. Zip Code	21132		10g. Citizen of What C USA	ountry?
# 807			by Funers	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
			To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1, 4or 5+)		ent's Usual Occup ind of work done O NOT use retired 1 Sales	ation during most of work d) Clerk	ring	Retail Sa	
8	land 2			17. Father's Name (First, Middle, Last) Raymond R. Merson 18. Mother's Name (First, Middle, Maiden Sumame) Carolyn V. Hudgins							
	Maryland	nd 2 shou Ith and M 27 is mer	-	19a. Informant's Name/Relationship (Ty) Theresa J. Pugsley		19b. Mailing	Address (Street Old Pyle	and Number or Run SVille Ro	al Route Numb ac, Whi	er, City or Town, State, teford, MD	Zip Code) 21160
90	nore,	ages 1 ar ant of Hee it: if itam y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	con	netery crem	ition <i>(Name of</i> atory or other place em. Park		Date 1/2006	20c. Location - City o Baltimore	
2/8/06	Baltir	permit. P Depertme importar eny injur		21. Signature of Funeral Service Ligense	Larlite.		Name and Addre	-	Delta,,	PA 17314	
557	7	0 9 0	edical Examiner								
# 45/	.O. Box (the death certificets y the attending phy sched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3 🔲	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
, Ruth =	Vital Records, P.	law requires that as been signed b 2 should be dete	To Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No Norsing Home Answer Answer Yes							
owley	Division of	To the Hospitel or Attending Physicien: The wiffin 24 hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Ptace of Injury - At hom	28b. Time of Injury	28c. Injur Wol M 1		28f. Location (how injury occurred Street and Number or I	
Rol				4 Homicide building, etc. (Specify) 239. Cutfiller 1X Certifying Physician: To the best of my knowledge death continued at the time date and place, and due to the cause(s) and manner as stated.							
("		ithin 24 hose the Fur	Medical	(Check only 2 Medical Examilione) 29b. Signature and title of certifier	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my o		rred at the time,	date and place, and do	
		± 3 ± 3		> Ke Arda	MIO	23a) /Tuna 1	DO	0622	01	Februar	y 9,2006
3		8		30, Name and addr ss of person who co	umir Chesa	LiDea K	EDr. E	Beldicul	mo :	21014	
		Sta Regist	ate rar	FFB 1 7 2006	32. Registrar's Signatu	Goscie					

			State of Maryland / Department of Health and M 1 - For State Registrar Certificate of Death		giene Reg. No.	06	0489	6					
	Division		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day	Year	3. Time of De	ath					
	Physici /Medio		Joseph Earhart Sardo III	Feb.	04	2006	6:30 a	am™					
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			ounty of Death							
			Genisis LaPlata Center LaPlata 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt		narles							
	Funeral Director		577 1/ 7030 1 YM 2 F 92 Wm Months Days Hours Min.	(Month, Day Oct 27	v, Year)	Cou	place (State or Fortry) $ington, I$						
			Usual Residence of Decedent	OCL. 27	, 101	. Wasii	riig coir, r	<u>DC</u>					
	yland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City L						
	e Ma	cto	VA. Fairfax Falls Church				1 🕅 Yes 2 [∐No					
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Acal Exandrae must be notified at	Funeral Director	10e. Street and Number 3101 South Manchester St.,#523 10f. Zip Code 22044		10g. Citize U	n of What Cou SA	ntry?						
	ams	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	. 14	Race - Ameri Black, White,							
36	safte , or it	by Fu	1 Never Married 2 Married 1 Tyres 2 No If Yes, Give 1 Yes 2 No Specify:			pecify: Whi	te						
Ö	hour tural	q pa	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h Kind	16b. Kind of Business/Industry								
75	in 72	olete	(Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)	ng	Top. Take of Dustriess industry								
21215-0036	d within Jiene.	Completed	Elementary/Secondary (0-12) College (1,4 or 5+) Resturant Manager		Pri	vate In	dustry						
Maryland	is 1 and 2 should be filed within 72 hours after dea of Health and Mental hyglene. Item 27 Is marked other than "natural", or itams other traumatic event, The Medical Examination	o Be C	17. Father's Name (First, Middle, Last) William H. Sardo, Sr. 18. Mother's Name Mary Ter			ımame)							
ary.			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I Route Numbe	r, Cîty or T	own, State, Zip	Code)						
	1 and 2 Health a tem 27 Is		James M. Sardo / Son 7606 Redwood Ct., Bra	andywine	e, MD	.20613							
Baltimore,	ss 1 a of Hei item		compteny crematony or other place)	ate	20c. Loca	tion - City or T	own, State						
Ē	Pages nent of I ant: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill 2/7/	′06	Suit	land. M	.D						
alt	permit. Pages Department of I Important: If it any injury or o		S/1/1 . / i - 1 1 1/1 i h i h i h i h i h i h i h i h i h i	edar Hil			ome						
ш	20729		Mary E. Nedgman 1319 4111 Pa. Ave., Sui			20746							
Physician /Medical Examiner		e	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	п гезрпатогу ал	1631,		Approximate Interval Betwee Onset and Dea						
P.O. Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	d by Physician/Medical Examine	cause. Enter Underlying Cause (Disease or irijury) that initiated events resulting in death) Last C. Due to (or as a consequence of): d.										
	the death certifi y the attending ched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		230	d. Date of delive Month	ery Day Year	ır					
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A Ch y m e (/ S dement) or	1-6	co use contribute to the cause of death?								
Division of Vital Records,	The law requires ate has been sign page 2 should be	Completed		24a. Was a autop perfor 1 ☐ Yes	sv	24b. Were auto prior to co death? 1 \(\sum \) Yes	ppsy findings avai mpletion of cause	ulable se of					
ital		ertification: To Be Co	0	0	0	a)	0	25. Was case referred to medical 26. Place of Death				2810	
Į.	ding Physician: h. After this certific funeral director,		examiner? 1 Yes 2 No	ne 5 ☐ Resid	e 5 Residence 6 Other (Specify)								
0 0	ng Pł fter tł neral		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of lnjury 28c. Injury at Work?	28d. Describe h	ow injury o	w injury occurred							
sio	Attending r death. sctor: Afte		2 Accident investigation M 1 Yes 2 No		Street and Alumbar or Duml Paulo Alumbar								
Σİ	I or Attending I after death. Director: After I in by the funer	artifi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	itreet and Number or Rural Route Number, rn, State)								
	Hospita 4 hours Funaral ely fillec	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
	To the within 2 To tha complet		one) and manner stated. 29b. Signature and title of certifier 29c. License number	- 2	29d. Date s	igned (Month,	Day, Year)						
)	F 3 F 8	-			10	1000	06						
R	(4)		J. Messer D55455 02/04/06 30. Name and Adress of person who completed cause of death (Item 23a) (Type, Print). Fatima Youse & Hussein 5025 Allentown Road Suite 101 Camp Springs Ma-20;										
	Sta Registr	-	31. Date filed (Month, Day, Year) FFR 0 6 2006 22. Registrar's Signature	Civi Ci	(char	ring & 1	4-201	TP					
	3,,		LED OF COOL										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10:05 P **ELSIE** SMITH JANUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MANOR CARE NURSING HOME LARGO Month, Day, Yeal 930 AUGUST 25 If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours 1 □ M 2 🔀 F ENGLAND 75 Director 562-96-8582 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County e how rthan "natural", or Iteme 23a or 28a-f ehov tra Medical Examinar must be notified at 1 Yes 2 □ No Director CHARLES LAPLATA 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 20646 8825 MARGARET COURT Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗷 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: white Completed by 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRTVATE HOUSE WIFE 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file pertment of Heelth and Mental Hy portant: If Itam 27 Is marked oth y Injury or other traumatic even Be UNKNOWN JIM WOOD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8825 MARGARET COURT LAPLATA, MARYLAND 20646 JIMMIE SMITH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/11/2006 FAIRFIELD, CALIFORNIA 4 ☐ Donation 5 ☐ Other (Specify) FAIRMONT CEMETERY permit.
Depertrainmports
eny Inju J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PARKINSON'S /Medical Due to (or as a consequence of): **Examiner** HYPOTHYROIDISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit FAILURE TO THRIVE Due to (or as a consequence of): Box 68760, Physician/Medicai ihe use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No õ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by been signe should be 1 Yes 2X No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2**X** No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Milatrew m.D. D47604 FEBRUARY 2, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOBHAN MATHEWS M.D. 3048 MITCHELLVILLE ROAD BOWIE, MARYLAND 31. Date filed (Month, Day, Year) State FEB 0 3 2006 Registrar

		For State Registrar	State of Mar		artment of H rtificate of I		d Mental Hygie	ene 1. No. 0 0 6	04898
Observator		1. Decedent's Name (First, Middle, Last)		1			2. Date of Death Month	Day Ye	3. Time of Death
Physici /Medi	cal			abatini			January	29, 2006	
Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of D	
_		5 Old Stage C 5. Social Security Number 6. Sec		In yrs. last birthday)	North E	If Under 24 H	Irs. 8 Date of Birth	Montgon 9.	Birthplace (State or Foreig
Funeral Director			M 2□F	88 Yrs.	Months Days	Hours M	in. (Month, Day,) April 22		Country) Vashington, l
yland		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
a-fet	to	Maryland Montgome	ry	North	Bethesda				1 TyYes 2 □ No
within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f ehow ha Madigal Exeminar must be notified at	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What	
s 23s	ra	5 Old Stage Co		or in II C 12		852			ates of Amer
tem them	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces?	er in 0.5.	If Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		Vhite, etc.
Pages I and 2 should be littled within 72 hours after beath with the maryran ment of Health and Mental Hydione. I ment of Health and Mental Hydione. I mental it if them 27 is marked other then "natural", or items 23a or 28a-1 ehow the mary page of the marked other them. The Medical Example must be notified at	by F	3 Widowed 4 Divorced	1 □Yes 2 □ No If Yes, Give 19 Year or Dates:	41-44	1 ☐ Yes 2X No	Specify:		Specify:	White
72 no	Completed	15. Decedent's Edu (Specify only highest grad	cation a completed)	16a. Dece	dent's Usual Occup	ation during most of v		6b. Kind of Busine	ess/Industry
ithin Per	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired)			
lygier lygier her th	ပိ	17. Father's Name (First, Middle, Last)	4		Builder	18 Mother's N	Name (First, Middle, Ma		ruction
ntal H	Be					10. 1101.101 3 1	tano (i noi, meso, m		UIRHOWH
mark matic	၉	Otis Sabatini 19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	ing Address (Street	and Number or	Rural Route Number,	City or Town, Star	te, Zip Code)
ith an		Elizabeth Jutz Sab					, North Bet		
Hea the		20a. Method of Disposition			osition (Name of matory or other place			0c. Location - City	
# # B		1 🗷 Burial 2 ☐ Cremation 3 🗹 F 4 ☐ Donation 5 ☐ Other (Specify)			National	1	erv	Arlingto	on, Virginia
Departm mportar any inju		21. Signature of Fyneral Service Licens		2	2. Name and Addre	ss of Facility			ring, MD 209
10 E • 0		3							Approximate
		23a. Part Enter the disease, or compleshock, or heart failure. List only o	ne cause on each line.			g, such as care	alac of respiratory arres	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	y Artery	Disease				10 + Year
xaminer		1	•	consequence of):	rt Diseas				10 + Year
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):	it Discar				
d anslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Emphyse	ma					10 + Year
ysician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
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ed by the ettending phr detached for use as th	Physician/Med	IF FEMALE:							
e ettending phi d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth 2	Fetal death 3	□Ectopic pregnancy	•		23d. Date of Month	delivery Day Year
the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tir 9☐Unknown	ne or death 5t	Other (specify)				
ned by the	Ph.	Part II. Other significant conditions co	ntnbuting to death buf	not resulfing in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
een sign	d by						1 X Yes	2 No 3	Probably 4 Unkno
been signe	Completed		-				24a. Was an	24b. Wer	e autopsy findings availa
ate hes b page 2 s	μc						autopsy perform	ext? deat	
(a) 1-7-	0	25. Was case referred to medical				26. Place of I	1 ☐ Yes 2		103 20110
	OB	examiner? 1 Tes 2 No	lospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursin	g Home 5 Resider	nce 6 Other	Specify)
terthis neral di	Di: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time (of 28c, Injui	y at k?	28d. Describe how	w injury occurred	
r death. ector: After by the fune	atle	2 Accident investigation				Yes 2□No			
Direct Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specity)	treet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	cal Ce	29a. Certifier 1 Certifying Phy	sicien: To the best of	my knowledge, dea	th occurred at the til	me, date and pl	ace, and due to the car accurred at the time, da	use(s) and manne	er as stated.
in 24 the F	ledicai	one)	and manner state						
To	Σ	29b. Signature and title of certifier	.1 . 1	١	29c. Licens		29	d. Date signed (A	31, 2006
10		Mulano	in My)	D326				
	1	30. Name and address of person who o	ompleted cause of dea	ath (Item 23a) (Type	, Print)	Road,	Suite 100,	Bethesd	a, MD 20817
		Thomas J. McNaman	,	S Signature		Noau,			

B.K.S		
ELLEN	V.	SCHNEIDER

State of Maryland / Department of Health and Mental Hygiene

			For 1 - State Registrar	Otate of W	arytariu /	•	tificate of D			leg. No.	06	04899
	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Ellen Vala						FEB.	2,20		2325 P M
7	Examir	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or				ounty of Death	
	<u>- 1941.</u>		POTOMAC RIVER		- // /	Lat. to 1	BETHESD If Under 1 Year	A If Under 24 Hrs.	8. Date of Birth		MONTGO	
	Funeral Director		227-04-4144	DM OFF	e (In yrs. last b	Yrs.	Months Days	Hours Min.	Month, Day Dec.10.	, Year)		pplace (State or Foreign untry) pan
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Mary	ō	Maryland Montgom	0237	Chevy	7 Ch	250					XXYes 2 □ No
	1 the	Director	10e. Street and Number	iel y	Office	, 011.	10f. Zip Code		1	10g. Citize	en of What Co	untry?
	h with	0	3815 Woodbine ST	1			20815			U.S	.A.	
	items items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spanic Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	Black, White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than *natural', or items 23s or 28s-f show event, the Madical Examinar must be notified at	b	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:		1	☐ Yes 2Ã No		,		Specify:	hite
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra		16	(Give)	ent's Usual Occupa kind of work done di	uring most of work	ing	16b. Kind	d of Business/	industry
21	S . c .	n de	Elementary/Secondary (0-12)	College (1-4or	5+)	life. E	OO NOT use retired)					
21	filed with Hygiene. Ither than		17. Falled Aller (First Middle Land	5+		Att	orney	18. Mother's Name	Circh Middle	La		
Pug Bug	should be filed with and Mental Hygiene marked other than matic event, the	Be	17. Father's Name (First, Middle, Last	,				Halfri			dsdott	ir
Ĕ	should ind Men marke	ဥ	Henry Schneider 19a. Informant's Name/Relationship (Tuna Print)	10	h Mailin	g Address (Street a					
Maryland	d 2 s		Matthew L. Jacobs	**	14-		10-2 (2005)					
	1 an Heel tem 2		20a. Method of Disposition	, nabbani		of Dispo:	Woodbine sition (Name of natory or other place	SI. Che	vey Cnas Date	20c. Loca	ation - City or	Town, State
Ω	Sec of Se		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				ek Cemete		8 06 4	Jashi	noton	D. C.
Baltimore,	permit. Pages 1 and Depertment of Heeli Important: if Item 2 eny Injury of other once.		21. Signature of Furgeral Service Lice		ROCK	22	. Name and Address	s of Facility Jo	seph Gav	vler'	s Sons	. INC.
ä	Depermi Depermi Impo		William 10	Durens			130 Wisco					
ľ			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that arese	d the death. Do	not ente	er the mode of dying	, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Hypoth		i C	onplicati		-			Onset and Death
	1	e	Sequentially list conditions if any, leading to immediate	b. Due to (or as	a consequence	a of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.								
o,	rificete be executed ng physicien and as the burial-transit		resulting in death) Last		a consequence	9 of):						
68760,	ate be nysici he bu	Aedicai		_ d								
	E 20 m	Med	IF FEMALE:								!	
P.O. Box	et the deeth cerr by the attendin stached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deal		Ectopic pregnancy Other (specify)			23	3d. Date of deli Month	very Day Year
	s thet ned by a deta	by Pt	Part II. Other significant conditions	contributing to death b	out not resulting	in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use	e contribute to	the cause of death?
rds	quires on sign uld be	다 다							1 🗆 Y	es 2 🕅	No 3□Pr	obably 4 DUnknown
Records,	. The faw requires thet the sete has been signed by the page 2 should be detached.	Completed							24a. Was a autops	med?	death?	topsy findings available completion of cause of
Vital	an: T tificel tor, p	0	25. Was case referred to medical		eesta .			26. Place of Deat	THE RESERVE	2 □ No _	1/Yes	2□ No
Σ	Physician: r this certifice ral director, I	To B	examiner? 1 ☐XYes 2 ☐ No	Hospital: 1 Inpati	ent 2 ERVC	Outpatien	t 3□ DOA Othe				Other (Spec	(by) AT SCENE
n of	g eg		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	y Year) 28b	Time of	28c. Injury Work	at ?	28d. Describe h	ow injury	occurred Su	bject entered
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	2 2	06 11	:33		/es 2 No				trowned
Division	s efter of Direct of Direc	Certification:	4 Homicide determined	280. Place of III	ic. (Specify)		eet, factory, office		City or Tow	n, State)	Potonia 2, Mi	iral Route Number, LC RLV W
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical		nysicien: To the best miner: On the basis o and manner st	f examination a							
	To the within 2 To the complet	Ž	29b. Signature and title of certifier				29c. License	number	2	29d. Date	signed (Monti	h, Day, Year)
	10		· Carol He	allanv	ud		0.C.	M.E		FEB.	4, 2	006
	1 ~		30. Name and address of person who	completed cause of			Print) I STREET,	BALTIMOR	E,MARYL	AND 2	21201	
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature		certi					
	Regist	ar	FEB 06	2006	and in	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. od / Department of Health and Mental Hydienen n a n l. 9 n n

		- 1	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of D			g. No.	0 14 3 0 0
	-		. Decedent's Name (First, Middle, Las					2. Date of Death Month	, 31, 20°6	3. Time of Death 06 6:45 P M
	Physicia /Medic	al l	Harold Siegrist			4b. City, Town, or	Location of Death	January	4c. County of I	
	Examin	er ⁴	a. Fecility Name (If not institution, give Holy Cross Hospi				Spring			ntgomery
	Funeral		. Social Security Number 6. S	9x 7. Ag	e (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		537-18-2380	□M 2□F	84 Yrs.			Nov. 20	, 1921	Washington
	land	—	Jsual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a-f eh	ctor	Maryland Montgo	mery	Rockvi				0g. Citizen of Wha	
	3a or 28	ᅙ	10e. Street and Number 13707 Parkland Di	cive		10f. Zip Code 20853			USA	
920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "nature!, or Iteme 23a or 28a-f show importent: if Item 27 is marked other then "nature!, or Iteme 23a or 28a-f show any Injury or other treumatic event, the Madical Examinar must be notified at ance.	by Fur	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces: †(₹Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13 No WWII	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:		Specify:	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dec	edent's Usual Occupa e kind of work done of DO NOT use retired	ation luring most of work)	ring	16b. Kind of Busin	ness/Industry
21215-0036	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 2	6 t)	tronic Te		i	Aerospac	e
d 2	i Hygir other	Be Co	17. Father's Name (First, Middle, Last,						Maiden Surname)	
ylar	Menta Menta arked atic ev	ToE	Gottlieb Siegri		40h Mai	iling Address (Street a	Katie Y		· City or Town. St.	ate. Zip Code)
Maryland	12 shc h and 7 ie m treum		19a. Informant's Name/Relationship (Harold L. Siegri:		3920	Havard St	reet, Wh	eaton, M	aryland	20906
Baltimore, I	Peges 1 and ent of Heeling of Heeling 2 ry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State		position (Name of ematory or other place Memorial		ruary 4	20c. Location - Ci ockville	ty or Town, State , Maryland
Baltin	permit. F Depertm Importer eny Injur		21. Signature of Funeral Service Lice	1 CP	,	22. Name and Address Francis J. 500 Univer	ss of Facility Collins sity Blv	Funeral d, W, Si	Home lver Spr	ing, MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do not e	inter the mode of dyin	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death
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,0928	cate be executed physicien and the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):					
Box 6	Attending Physician: The law requires thet the death certifics rdeath. rdeath. sctor: After this certificate has been signed by the ettending pt by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date Mont	
s, P.O	es thet thighed by	by Ph	Part II. Other significant conditions		but not resulting in the	underlying cause giv	ren in Part I.			oute to the cause of death? B ☐ Probably 4√√Unknown
ord	w require been sign	ted	Hypoalbuminemia,	Dementia				24a. Was	· · · · ·	
Rec	helawı ehasb ege 2st	Completed						autop	rmed? de	ere autopsy findings available for to completion of cause of lath? Yes 2 No
ital	lan: T	BeC	25. Was case referred to medical examiner?			011		ath (Check only o		
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ono	ding F h. After funera	tlon	1 Natural 5 Pending 2 Accident investigate	28a. Date of In (Month, L	ay Year) Injur	y Wo	rk? ∣Yes 2 □ No			
Division of Vital Records,	l or Atten efter deat Director: I in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he compisiely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physician: To the be- miner: On the basis and manner	st of my knowledge, do of examination and/or stated.	eath occurred at the ti r investigation, in my	me, date and place opinion, death occ	urred at the time,	date and place, an	
	To the comple	Me	29b. Signature and title of certifier	Plan	ala	7	se number 2261		-	(Month, Day, Year) ary 1, 2006
	1		30. Name and address of person wh Alan R. Segal,	M.D /1	517 Hugo C	ircle Silv	ver Sprin	ıg, MD 20	906	
	S: Regis	ate trar	31. Date filed (Month, Day, Year) FEB 0 6 20	106 Regi	strar's Signature	arte				

DHMH 17 Rev 1/2001

		-	1 - For State Registrar	State of	Marylan		artment tificate			and M	lental Hy	giene Reg. No.	2006	04	901
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea	Bay	Year	3. Time o	
	Physicia /Medic		Victoria Ann Smit	h							Feb	-	2006) <u>A</u> M
سز	Examin		4a. Facility Name (If not institution, give 42 Broadway, Apt.		er)			rown, or gerst				7	ounty of Deat Vashing		
	Funeral Director		5. Social Security Number 6. S 212–58–9416	9X 7. □ M 2 🗆 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 10/22/	h y, Ye <i>ar)</i> 1950	9. Birti	hplace (State untry)	or Foreign C
	pu ≱		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside (City Limits
	shored	ō		on		lagerst								1 ₇ √2 Yes	s 2□No
	the N	ect	MD Washingt 10e. Street and Number	011		абсты	10f. Zip	Code				10g. Citiz	en of What Co	untry?	
	with 3a or		42 Broadway, Apt.	2			21	740				Ţ	JS		
	ms 2:	era	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	. 1	4. Race - Ame Black, White		
9	filed within 72 hours after death with the Maryland Hygiene. bthe than "natural", or Items 23a or 28a-f show ent, the Macilcal Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	1 Types 2 If Yes, Give Year or Date	□ No		1 ☐ Yes 2		Specify:		, , , , , ,			lack	
003	ural',	d b	3 ☐ Widowed 4 ☐ Divorced		es:	16a Docar	dent's Usua	I Occupa	ition			16b Kin	d of Business/	industry	
15	n 72 nat	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of wor DO NDT us	k done a	lu <i>ring</i> mos	t of work	ing	100. 14		,	
12	withi	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		Hea	alth_	Care			S	ocial S	ervice	es
Þ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)								(First, Middle,				
ylaı	2 should be f and Mental I is marked of raumatic eve	To E	Harold Wesley Smi								a Louis			Ti- O- de l	
Maryland 21215-0036	12 sho h and 7 is m Iraum		19a. Informant's Name/Relationship (Chad W. Smith / S								a <i>i R</i> oute Numbe Hagerst				
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if them 23 or 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, The Medical Examiner must be notified at		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of		-	Date		ation - City or		
5	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from St	ate	ithsbu	g Cre	emato	or. 0	2/07	/2006	Smi	thsbur		
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n of	Jing Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Injury , Day Year)	28b. Time o Injury	f 2 M	8c. Injury Work	≀at ⟨? Yes 2.⊡	No	28d. Describe	now injury	occurred		
Division	or Attendated death Director:	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place o	of Injury - At h g, etc. (Speci	nome, farm, st ify)					28f. Location (. City or To	Street and wn, State)	Number or R	ural Route Nu	ım <i>ber</i> ,
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			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)			100	117/0				
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<i>3</i> .	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death	1
	Examín	er	Washington Count			Ha	gerstown		Washi	naton
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	9 Rinth	nplace (State or Foreign untry)
Į.	Director		217-28-7095] M 2 XX F	74 Yrs.	World's Days	110010	Mar.15,19		ryland
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	ylan how		10a. State 10b. County	'	0c. City, Town or I	Location				1 ☐ Yes 2 XNo
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	dea dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black, White	
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5	ysicia is cert direct	To B	examiner?	Hospital: 1 Inpatier	nt 2 ER/Outpa	tient 3 DOA	then 4 Nursing	Home 5 Residence	e 6 □Other (Spe	ecify)
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ORIGINAL

John E. Smathers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27, pen/ff, 9853,3/22/06 TT State of Maryland / Department of Health and Mental Hygiene 06-00889 NJM Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 1855 February John E. Smathers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard <u>Columbia</u> <u> Howard County General Hospital</u> If Under 24 Hrs. 8. Date of Birth
| Month, Day, Year Birthplace (State or Foreign Country) If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** 1**⊠** M 2□ F 4, 1958 Maryland Yrs. May 47 579-84-6422 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in than "natural", or itame 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director West Friendship Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21794 2911 New Rover Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Army 1XX Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 45 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) la marked other than Law 5+ yrs Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Carmella Gesuero Spurgeon E. Smathers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10314 New Gate Ct. Ellicott City, Md. 21042 Peges 1 and 2 iment of Heelth a tent: If itam 27 is Luanne Tano/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State ö Arlington National Cem. 3/13/2006 Arlington, Va. permit. Pege Depertment of Importent: If eny injury or ance. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F. H. Inc. 21. Si natu of Fu≕ral Service Li en ∞ e 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications of Aortic Stenosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit or Attanding Physician: The law requires thet the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 ∭Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1,☐ Yes 2☐ No 24a. Was an autopsy performed? 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2/ER/Outpatient 3 DOA Yes 2□ No Certification: To this 28d. Describe how injury occurred 28c. Injury at Work? After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No investigation death. neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 | Homicide hours after within 24 hours a 1 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February, 5, 2006 OCME マン 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) 2)02 Baltimore, Maryland 21201 111 Penn Street COUNE Miking 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **FEB 07** 2006 alux. Registrar

			- FOI	partment of Health and Mertificate of Death	Reg. N	UUD	04904
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	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 1 M 2 F 81 Vrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea) 03-19-1924	9. Birthpl Coun Mary1	**
	yland sow		10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
	e Mar	Director	MD Somerset Deal				1 Yes 2 No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Coun	try?
	ns 23	eral		21821 3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumetic event, the Madical Examinar must be notified at once.	by Funeral	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerio	Rican, etc.)	Black, White, of Specify:	
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<u>la</u> n	Jental Jental rked c	To Be	Walter Jachimowicz	Marie M	laska		
lary	2 should and Men is marke eumetic			iling Address (Street and Number or Run			
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<u>~</u>	Depa impo any ir		M00295 23a. Part1. Enter the disease, or complications that caused the death. Do not e	11673 Somerset Ave	Princes:	s Anne, M	21853 Approximate
	Physician /Medical Examiner physician and physician and physician ithe printing from the physician at the physician physician at the physician phy	Examiner	shock, or heart failure. List only one cause on each line.	structive Lung		re_	Interval Between Onset and Death
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Division of Vital	ding Phys h. After this funeral di	tion: To	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Notatural 5 Pending (Month, Day Year) 2 Accident investigation 2 Accident	of 28c. Injury at	28d. Describe how inj		//
Divisi	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Centifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control of the desired form of the pass of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause(red at the time, date a	s) and manner as si nd place, and due to	ated. the cause(s)
	To the within To the comple	Ž	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
}			, Om	D 54422	1	20./1/	0
			30. Name and address of person who completed cause of death (Item 23a) (Type Sarad Baral, M.D., 1604 Market Street		MD 21851		
:	Sta Regist		31. Date filed (Month, Day, Year) 32. Registar's Signature FEB 0 8 2006				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 832 **Physician** 2006 largaret /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Maryland Lowerst If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 M 2 F 2 Yrs 213-01-5666 MARYLAND 1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Exeminer must be notified at 1 ☐ Yes 2 👿 No Director **QUEENSTOWN QUEEN ANNE** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21658 USA 241 BRYCE ROAD or items 23a death 1 Completed by Funeral 14. Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after cent of Health and Mental Hygiene.
ner if item 27 is marked other than "natural", or liter uny or other traumatic event, the Macalcal Exeminer 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 6 -0-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GRACE TARR JAMES GARRETT RUTH မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 903 CHESAPEAKE DRIVE, STEVENSVILLE, MD 21666 DEBBIE THOMAS/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-7-2006 EASTON, MD 21601 WOODLAWN MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 nonde hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final ubdural 39 hows brain **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MEDICAL Due to (or as a consequence of) Examiner The law requires that the death certificate be executed 3 that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 0500 AM 1 Yes 2 No Standing death. 31,20-6 from 2. Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
271 Dry Road 3 Suicide in by within 24 hours after To the Funerel Direct 4 THomicide ancers how ~ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

carsz

31. Date filed (Month, Oay,

University

32. Registral's Signature

		•	1- For State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygier	ZUUh	04906
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		CHARLES WESLEY	SPENCER	FEB. 4	2006	8:36 A M
7	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			410 BALDWIN PARK DR., APT. 1A	WESTMINSTER		CARROL	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	ar) 9. Birth	place (State or Foreign
	Director		213-32-7333		Aug. 22,	1948 Mai	ryland
	and w	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	daryli I eho	ō	Maryland Carroll Westmi	nster			1√2 Yes 2 No
	28a-	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	With With		410 Baldwin Park Drive - Apt 1A	21157		U.S.A.	
	death with the Maryland ms 23a or 28a-f ehow	Funeral		B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer		14. Race - Ameri	
_	or ite		1 ☐ Never Married 2 ♣ Married 1 — Yes 2 ☐ No		to Hican, etc.)	Black, White	etc.
2-003p	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f ehow ledical Examinar must be nutified at	ğ	3 □ Widowed 4 □ Divorced II ♣es, Give Year or Dates: Vietnam	1 ☐ Yes 2 ☐ No Specify:		Specify: WI	nite
ج د	72 hc	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation we kind of work done during most of wo	rking 16b	. Kind of Business/Ir	ndustry
V	within then the Mes	du	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)			
V	be filed withir tal Hygiene. d other than event, it e M		12 CC	nstruction Worker	me (First, Middle, Maid	Construct:	Lon
yland	o a b e	Be					
_	2 should be and Ment is marked reumatic e	ျှ	Paul E. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or R	n Mae Wa:		n Codel o a a s
<u> </u>	s 1 and 2 should t Health and Mer Item 27 ie marke other treumatic		100-000-00				
δ.	of Health Item 27 other tr		Norma Spencer - Wife 410 20a. Method of Disposition 20b. Place of Dis	Baldwin Park Driv	Date 20c	. Location - City or T	own, State
IIII	Pages nent of int: if it ury or o		1 Desurial 2 Cremation 3 Hemoval from State	rematory or other place)	10.106		37 3 1
	permit. Pages Depertment of I Important: if to eny injury or o		TOPICE	prings Cemetery 2 22 Name and Address of Facility TO LESWOTTH WILLIAM			
g	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1 4 gal 1 th		-		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e	6401 Ridge Road, onter the mode of dying, such as cardia	c or respiratory arrest,	Maryland	20872 Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	co.	DA		Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	Welmatord	<u> </u>		
	Examiner		Sequentially list conditions. b. Severe	2holmatord 1	Frening		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
	nd trans	Examiner	that initiated events c.				
90,	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
XX	physic	dical	d				
٥ ×	eath certificate attending phys for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	root.
X Q Q	atter for u	ian	in the past 12 months?	B □Ectopic pregnancy Discreping		Month Month	Day Year
j	at the de by the a tached	Physician/Med	1 Yes 2 No 9 Unknown				
J.	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds,	w requires that been signed b should be deta	d by			1 1 1	2 No 3 Pro	bably 4 Unknown
Cord	≥ □ ਯ	Completed			24a. Was an	24b. Were aut	opsy findings available
Š	The lay	E			autopsy performed 1 ☐ Yes 2 ☑	? death?	ompletion of cause of
Vital		a	25. Was case referred to medical	26. Place of De	ath (Check only one)		
	S 0 0	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other: 4 Nursing	Home 5 Bestdence	e 6 □Other (Spec	ify)
Ö			27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)		28d. Describe how i	njury occurred	
<u> </u>	Attending r death. ector; After by the fune	atic	2 Accident investigation	M 1 Yes 2 No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of tnjury - At home, farm, building, etc. (Specify)	street, lactory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
_	pitai v urs e arai D		200 Contilier 45 Anistin Studies T.		a and due to the sec	o(a) and =	gtatod
	To the Hospital or Attsndi within 24 hours efter death. To the Funeral Director; A completely filled in by the fu	Medical	29a. Certifier (Check only one) Check one) Check only one) Check only one) Check one) C	investigation in my opinion, death occ	urred at the time date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	. Day, Year)
)	ν σ + ε + σ	W	Kanlocoma MD	D-0054	218 0	2-05-	-06
-	LXIVI	ı	30. Name and address of person who completed cause of death (Item 23a) (Typ	ne, Print)			
-	71.		DR. Raman B Kanena 34°	29c. License number D - 0054 Mol Calmy duve	West-Mir	ster MD.	21157
	Sta		31. Date filed (Month, Day, Year) 2006 32/ Registrar's Signature	Society			
	Registr	ar	Manage of the second				

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment <i>rtificate</i>	of He	ealth a <i>eath</i>	ınd M		giene Reg. No		6 (04907
	di.		1. Decedent's Name (First, Middle, Last)							2. Date of De			V	3. Time of Death
¢	Physici		DAVID JAMES SNYDER	t						Month Janua	rv 3	y 0, 2	_{Year} 006	1:20 p M
	/Medio Examin		4a. Facility Name (If not institution, give s			4b. City, To	own, or L	ocation of	f Death			County		
		36	Laurel Regional Ho	spital		Laur	e1				P	rinc	e Geo	orge's
-	Funeral	-	5 Social Security Number 6. Sex	7. Age (In vrs.	last birthday)	If Under 1 Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bit (Month, Da	th V Year)		9. Birthpl	lace (State or Foreign
	Director		213-24-3602	M 2□F 75	Yrs.	WOILITS	Days	Tiodis	141111	Sept. 3	0, 1	930		sýlvania
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	cation							10	0d. Inside City Limits
	aryla shov	7												1 X Yes 2 No
	Ne M	Director	Maryland Prince Ge	orge's Hya	attsvi) - d -				10- 04	i of 10	/hat Coun	
	with t		10e. Street and Number			10f. Zip C							mat Coun	uyr
	e 23	Funeral	5410 Gallatin Stre	et 2. Was Decedent Ever in U.	C 12.1		781	nania Oria	in2/Con	oifu Van or No		S.A.	- Americ	an Indian,
	er de Item	nu	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	50-	f Yes, specif	y Cuban,	Mexican,	Puerto F	cify Yes or No Rican, etc.)	,-		k, White,	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2	No	Specity:				Specify:	Whi	te
Ö	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show dical Examinar must be notified at	ed	15. Decedent's Educ	ation	16a. Deced	dent's Usual	Occupati	ion	,		16b. K	ind of Bu	siness/Inc	lustry
115	n n	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	kind of work DO NOT use	done dui retired)	ring most	of workir	ng .	Uni	ted	State	es
212	d within giene. rr then "	Completed	10	College (1-401 3+)	Posta	al Cle	rk				Pos	tal	Servi	ice
b	be filed within 72 hours after death with the Marylan ital Hygiene. Indicate then "natural", or Iteme 23a or 28a-f show event, the Madical Examinar must be notified at	0	17. Father's Name (First, Middle, Last)				1	8. Mother	r's Name	(First, Middle	, Maiden	Surname	э)	
lar	should be and Mental marked o	To B	Charles T. Snyder					Mart!	ha J	ane Jai	nes			
ary	2 should be and Mental le marked raumatic ev		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street an	d Number	r or Rura	Route Numb	er, City o	or Town,	State, Zip	Code)
Σ	alth a		Patriciaann Snyder	- Wife	5410	Galla	tin	Stre	et,	Hyatts	vill	e, Ma	ary1a	and 20781
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Deperment of Health and Menta Important: if Item 27 Is marked any Injury or other traumatic enong.		20a. Method of Disposition		lace of Dispo em <i>etery, cren</i>	sition (Name	of er place)		D	ate	20c. Lo	ocation -	City or To	wn, State
Ĕ	Page nent int: If		1 ⊠Burial /2 □ Cremation 3 □Re 4 □Donation 5/□ Other (Specify)		t Linco	ıln Cem	etery	y 2	1/6/2	006	Bre	ntwo	od, l	Maryland
alti	permit. Deperting the post of		21. Signature of Funeral Service License	· h /	22	. Name and	Address	of Facility	Gas	ch's F	unera	al Ho	ome,	P.A.
0	88558		Kalent (1//24	4	4739 B	alti	more	Ave	., Hyat	ttsv:	ille,	, MD	20781
***	4, 4		23a. Part1 Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	n. Do not ente	er the mode	of dying,	such as c	cardiac oi	r respiratory a	rrest,			Approximate Interval Between
do	Physician		Immediate Cause (Final disease or condition	Cerebrovascu	ılar Ad	cciden	t							Onset and Death 6 Days
1	/Medical		resulting in death)	Due to (or as a consequ										0 24,0
	Examiner		Sequentially list conditions b.	Acute Renal	Failur	e								8 Days
		ner	if any, leading to immediate	Due to (or as a consequ	uence of):									
	cutec nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Sepsis, Unkr	nown Sc	ource	of I	nfect	tion					8 Days
ó	an ar	EX	resulting in death) Last	Due to (or as a consequ	uence of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dical	d.			_								
9	rtifice	Med	IF FEMALE:										1	
Вох	eath certific attending p I for use as	an/	23b. Was decedent pregnant	ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pred	gnancy					23d. Date Mon	of delive	ry Day Year
E	ne dea the at hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (spec	rfy)					NIOI	1113	Day 16a
P.O.	that the de ed by the detached	Physician/Me	9 Unknown											
	res tha igned be de	þ	Part II. Dther significant conditions cont Diabetes Mellitus	nbuting to death but not resu	ulting in the ur	nderlying cau	ise given	in Part I.						e cause of death?
ord	w requir been si should	Completed				-				10	Yes 2.	MO	3 Prob	ably 4 Unknown
ecc	e law r has be je 2 sh	ple								24a. Was auto	psy	24b. V	Vere autor	osy findings available inpletion of cause of
<u> </u>		о́п								perfo	ormed? 2 X No	d	eath? □ Yes	
Division of Vital Records,	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only	one)			
<u>></u>	nysic lidire	ည	1 ☐ Yes 2 🕅 No	ospital: 1 🖾 Inpatient 2 🗌	ER/Outpatien	t 3□ DOA	Other:	4 □ Nur	sing Hon	ne 5 ⊟ Resi	dence	6 □Othe	r (Specify	')
0	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	280	c. Injury a Work?	nt	2	8d. Describe	how injui	y occurre	ed	
Sio	Attending r death. ector: Afte	catl	2 Accident investigation			М	1 🗌 Ye	s 2 🗆 N	- !					
Ë	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stri	eet, lactory,	office		2	8f. Location (City or To			r or Rura	l Route Number,
	oltal c		V	<u> </u>										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examin	cian: To the best of my knower: On the basis of examinat										
	To the within 2. To the complet	Med	one)	and manner stated.		200	License r	number			yad De	le siana-	(Manth I	Day, Year)
\	5 ± 5 0	-	29b. Signature and title of conflier	///			2409:					-		
_ /	(a) 111		/ manca	Menso			∸ + ∪ フ .	<i></i>			Jan	uary	31,	2006
4	(0) 1Va		30. Name and address of person who con			,		200	D.	1 1	3.6	- 1	1 00	7.2.7
1	1.00		Mark Parkhurst, MD 31. Date filed (Month, Day, Year)	5711 Sarvis		e, Su	rte 2	200,	KIVE	rdale,	Mar	yLan	a 20	131
100 M	Sta Registr	_	FFR 0 3 2006	Marie & Signal	An	8								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** January 31, 11:23 a M William Sabin 2006 Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3210 North Leisure World Blvd. Montgomery Silver Spring | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Oct. 23, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** № M 2 . F 1926 North Carolina 79 Director 215-20-3317 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: it item 27 is marked other than "natural", or lieme 23a or 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 21 No Silver Spring Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 3210 North Leisure World Blvd. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury of other termantic event, the Medical Exerci Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: WWII þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Law 5+ Tax Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Abigail Cooper Arthur Sabin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 North Leisure World Blvd., Silver Spring MD 2090 Marie Klodsen Sabin/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) February 1, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Metropolitan Crematory 2006 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature A Funeral Service License Francis Address Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Renal Cell Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2₩ No 1 Yes certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 1X Natural 5 Pending investigation after death.
Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel C 29a. Certifier 🎦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 20+1 D35635 February 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, M.D. 18111 Prince Philip Drive, #327, Olney, MD 20832 Joseph Kaplan, M.D. 31. Date liled (Month, Day, Year) 32 Registrar's Signature State FEB 03 2006 Registrar

			State		artment of Health and rtificate of Death		ene 0 0 6	04909
			1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		TILLIE		STERN	JANUARY 3	Day Year 31, 2006	5:15 A ^M
ķ.	/Medic Examin		4a. Facility Name (If not institution, give street and nur	n <i>ber)</i>	4b. City, Town, or Location of Dea		4c. County of Death	
			HEBREW HOME OF GREATER W	ASHINGTON	ROCKVILLI	Ξ	MONT	[GOMERY]
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	ff Under 1 Year If Under 24 Hr Months Days Hours Mir	(Month, Day, Y	(ear) 9. Birthp	place (State or Foreign
	Director		096-38-5313 1□M 2□xF	98 Yrs.		FEB 27, 1	1907	NY
	pu 🔉	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. fnside City Limits
	eho eho	ក						1 X Yes 2 □ No
	28a-f	Director	MD MONTGOMERY 10e. Street and Number		ROCKVILLE 10f. Zip Code	100	7. Citizen of What Cou	ntry?
	with a or	급	6121 MONTROSE ROAD		20852		U.S.	
	death with the Maryland ms 23s or 28s-f show r nust be notified at	Funeral	11 Marital Status 12. Was Dece	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (ff Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	can Indian,
0	or iter	Fur	1 Never Married 2 Married 1 Yes	2 X No		irto Hican, etc.)	Black, White,	
2	filed within 72 hours after death with the Marylar Hygiene. Ither than "natural; or itama 23a or 28a-f show int, the Medical Examiner mast be notified at	þ	3 X Widowed 4 ☐ Divorced If Yes, Giv Year or D	/e ates:	1 ☐ Yes 2 🎇 No Specify:		Specify:	WHITE
ה ה	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of w	orking 16	6b. Kind of Business/In	dustry
7	ithin Jen.	npi	Elementary/Secondary (0-12) College (1	1-4or 5+)	DO NOT use retired)			
V	led w lygier her ti		12 17. Father's Name (First, Middle, Last)	HOME	MAKER 18 Mother's N	ame (First, Middle, Ma	OWN HOME	
	be fi	Be	JACOB WOLFE		SARAH B		iden bumame)	
چ	d Mer nark	2	19a. Informant's Name/Relationship (Type, Print)	19h Maili			City or Town State Zin	Code)
Z Z	d 2 sho th and 7 ts m traum	ÜĬ			ing Address (Street and Number of			2012/08/2012
a)	1 and Health iem 27		MELVIN KRUPIN - SON IN I 20a. Method of Disposition	20b. Place of Dispe	WILLARD AVE, CHI	Date 20	Dc. Location - City or To	20815 own, State
2	Pages nent of int: if it		1X Burial 2 ☐ Cremation 3 X Removal from 4 ☐ Denation 5 ☐ Other (Specify)	State	matory`or other place) H CEMETERY 02/(02/2006 RI	IDGEWOOD, 1	IEW IEDCEV
altimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygiens. Department of Health and Maralla Hygiens. If them 27 is marked other than "natural; or itama 23a or 28a-f ehow may higher or other traumatic event, the Medical Examiner must be notified at once.		21. ignature					NEW JEKSEI
Ö	Dep imp gny	. /	(1000)		2. Name and Address of Facility DWARD SAGEL FUNER 1091 ROCKVILLE PI			AND 20852
			23a. Part . Enter the disease, or complications that of	aused the death. Do not en				Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on a	acriline.	ant fulow			Onset and Death
	/Medical		disease or condition resulting in death) a	(mas a consequence of):	1: 2	^		July 1
	Examiner		HAH)	teros class	tic Cadiovas	aller the	na (Kasa
		ner		(or as a consequence of):				(
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Š	be execut ician and burial-trar	Ë	resulting in death) Last Due to	(or as a consequence of):				
g/en	cate be ex physician the buria	dlcai	d					
٥	ding p	We.	IF FEMALE:	tcome of pregnancy			024 Data 44-6-	
o n	it the death certifii by the ettending p teched for use as	Physician/Me	is the past 12 months?	ointh 2 ☐ Fetafdeath 3[☐Ectopic pregnancy ☐ Other (specify)		23d. Date of defiv Month	ery Day Year
o.	the de y the e	ysic	1 ☐ Yes Ø No 4 ☐ Pregr 9 ☐ Unknown 9 ☐ Unkn					
7.	that the by detect		Part II. Other significant/conditions contributing to d	eath but not resulting in the t	underlying cause given in Part I.	23e. Did toba	acco use contribute to I	he cause of death?
gs,	requires that een signed t hould be dete	d by	Dementa.			1 ☐ Yes	2 □No 3 □ Pro	bably 4 Unknown
Hecord	> 0 0	Completed	Dotonathrita			24a, Was an	24b. Were auto	oosy findings available
ě	e la has	m d	08/0000 0000			autopsy performe	ed? death?	opsy findings available ompletion of cause of
Vital	ician: Th certificete ector, pag	ပို	25. Was case referred to medical		26 Place of D	eath (Check only one)	No 1 □ Yes	2 No
	Physician: this certific ral director,	0 0	examiner? Hospitaf:	Inpatient 2 ER/Outpatie	Other		ce 6 □Other (Speci	fv)
0	g Phy erthii	-	27. Manner of Death 28a. Date			28d. Describe how		
<u></u>	Attending F r death. ector: After by the funera	atio	2 Accident investigation	an, Day 1 Dany	M 1 Yes 2 No			
Division	r Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place build	of Injury - At home, farm, sting, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	ital o urs aft rai Di							
	he Hospital or Attendin n 24 hours after death. he Funeral Director: Af	Medical	(Check only 2 Medical Examiner: On the b	asis of examination and/or in	ith occurred at the time, date and planvestigation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as : te and place, and due t	stated. to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	ner stated.	29c. License number	290	d. Date igned (Month,	Day, Year)
}	6 1 2 1		1 Chants		1003528	31	1/3/14	
	V		30. Name and addr ss pers in which completed cau	se of death (Item 23a) (Type	^	0 1	11	
			Andres L Knight	: 6/21 MA	un se Koan	Locker	H, UN	20850
	Sta	ate	3 . Date filed (Mon'n, Yay, Year) 3P	legistrar's Signature	and a		V	
1	Registi	ar	FFR 0 3 2006	Lane At All	ALCONOMIC STREET			

Amended #6, nls, 01/25/06, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland	,	artment of r rtificate of	nealth and iv <i>Death</i>	, ,	leg. No.	04910
í	Physicia	an	1. Decedent's Name (First, Middle, I						2. Date of Dea		3. Time of Death 10:35 P M
	/Medic	al	Roselyn Lowery Sit				Ab City Town o	r Location of Death	Janua	4c. County of Dea	
	Examin	er	Frostburg Village N		enter		-	Frostburg		Allegany	
	Funeral			Sex 7. Ag	ө (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birth Month, Day 05-Jun-1	9. Bit	thplace (State or Foreign
	Director		002-18-2147	1₩ 2 X F	82	Yrs.	Wiotiurs Days	Tiodis telli.	05-Jun-1	923′ Maš	sachusetts
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ecation				10d. Inside City Limits
	Mary -1 sho	ţŏ	Maryland Alleg	any	Mour	nt Savag	ge				1 Yes 2 □ No
	d within 72 hours after death with the Maryland giene. rr than "netural", or items 23e or 28e-f show the Medical Examiner must be notified at	Director		Outch Hollow R	oad, N.	W.	10f. Zip Code			log. Citizen of What C	ountry?
	ath wil						21545-			U.S.A.	
	er de items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		5. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
350	within 72 hours after ene. than "netural", or ite the Modical Examina		1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗖 If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 1 No	Specify:		Specify. Wh	ite
21215-0036	2 hou	Completed by	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Business	
, i	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retired	d)	ing	retirement ho	nme
	filed will Hygier other the		17. Father's Name (First, Middle, La.	0		cook		18. Mother's Name	/First Middle		
/land	2 2 2 2 2 A	Be c	Waldo Leland	51/				Mary Darl		wallen Sumamey	
	should be not Menta marked umatic ev	은	19a. Informant's Name/Relationship	(Type, Print)						r, City or Town, State,	
Ma	and 2 salth a n 27 ia		Paulette Weber	daughte	r	957 D	oris Street	LaV	ale	Maryland	21502
ore,	es 1 a of Hea f item r othe		20a. Method of Disposition 1 Burial 2 Cremation 3	□ Removal from State	20b. Pla	ace of Dispo	sition (Name of matory or other plac	(90		20c. Location - City or	
Ĕ	Pages ment of lant: If it		`4 □Donation 5 □ Other (Spec	city)	Rest		emorial Gard		Jan-2006 C	Cumberland Ma	aryland
Баппо	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ODCB.		21. Signature of Funeral Service Lic	M)1171	1	22	. Name and Addre Durst Funer	ss of Facility al Home, 57 F	Frost Ave.	Frostburg, MD	21532
	- W. D.		23a. P. 1. Enter the disease, or co hock, or heart failure. List on	mplications that caused	I the death.	Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	acute		ebra	linfa	retion			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as							
		_	Sequentially list conditions,	b. — Due to (or as	a consequi	ance of):					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Fill a linearlying Cause (Disease or injury that initiated events	Due to (01 as	a conseque	31100 01).					
<u>.</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):					
68/6U,	tificate be executed by physician and as the burial-transit	edical		d	<u>-</u>						
	± Συγέ		IF FEMALE:					-			
o n	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	iclan/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal o	death 3	Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	time of dea	ath 5∟	Other (specify)				
7	that ti ed by detac	y Physi	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
SD	n sign	ed by	Congestiv	e Heart	fai	lune			1 🗆 Y	as 2□No 3□P	robably 4 Unknown
vitai Records,	s bee	ompleted	Advanced		obsh	nictiv	e lune	disease	24a. Was a		utopsy findings available
T T	The lav				· · · · · ·				autops perform		completion of cause of
<u>ra</u>		BeC	25. Was case referred to medical examiner?					26. Place of Death	Check only on	18)	
010	hys his	2	1 ☐ Yes 2 No							ence 6 Other (Spe	ecify)
	ng fter ine	tlon:	27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Inju (Month, Da	Y Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	280. Describe no	ow injury occurred	
UIVISION	i or Attending after death. Director: After I in by the fune	fical	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inj	ury - At horr	ne, farm, str	eet, factory, office			treet and Number or R	ural Route Number,
2	al or /	Certification:	4 Homicide	building, et	c. (Specify)				City or Town	n, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manner sta	examination	ledge, death on and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	ro the	Med	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	4/1		Worsock	Phi A	10		Doc	55325		Jan 25,	2006
	611		30. Name and address of person wh	completed cause of d		23а) (Туре,	Print)				
	Mhs		31. Date filed (Month, Day, Year)	N MD 48	S Taz	m Te	errace	Frostbu	ng MY	121532	
	Sta Registr	4.	JAN 2 5 20		o orgrado	x do	3060				

cian	1 - For State Registrer	State of W		rtificate o	Health and M f Death		2006	04911
cian	Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death
lical	George Ro	ob ert Sw	inson			Month February	y 3, 2006	8:11 P M
iner	4a. Facility Name (If not institution	, give street and number)		4b. City, Town	, or Location of Death		4c. County of Deat	h 🦸
1	2259 Bethleher 5. Social Security Number		e (In yrs. last birthday) If Under 1 Yea	Oakland ar If Under 24 Hrs.	O. Data of Righ	Garret	
	212-88-0625	1 X M 2□ F	35 Yrs.	Months Day		8. Date of Birth (Month, Day, Y) Oct. 28,	9. Birti 1970 Spa	nplece (State or Foreign untry) LIN
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Director	MD G	arrett		0ak1a			233	1 Yes 2 No
ă	2259 Bethleher	n Pond		Tot. Zip Code	21550	109	. Citizen of What Co USA	untry?
Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	
by	1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☑ N	uban, Mexican, Puerto i o <i>Specify:</i>	nicari, etc.)	Black, White	e, etc. Vhite
ted	15. Decedent (Specify only highes	's Education		dent's Usual Occ		16	b. Kind of Business/I	ndustry
Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5	life.	DO NOT use retii	e during most of workii red) oom Worker		Data Entr	y Company
Be C	17. Father's Name (First, Middle,	Last)	F.	11411 10	18. Mother's Name			y company
ToB	Robert Alto				Judith	Ann	H1ggins	
	19a. Informant's Name/Relationsh		1.		et and Number or Rura			
	Robert A. Swins 20a. Method of Disposition	son/Father	20b. Place of Dispo		hem Road,		Md. 21550 c. Location - City or 1	
	1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemetery, cre	matory or other pi	lace)			
	21. Signature of Funanti Service		Deer Par	2. Name and Add			eer Park, S. Second	
	Bladle N	Money		Stewart	Funeral Ho		kland, Md.	
8 1	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each III	the death. Do not enne. 1 Palsy	ter the mode of dy	ying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as	a consequence of):					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					· · · · · · · · · · · · · · · · · · ·
Examiner	that initiated events resulting in death) Last	C. Due to for a	2 0000000000000000000000000000000000000					
_	and a second second	Due to (or as	a consequence of):					
edic		d						
M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of delive Month	very Day Year
ysicia		De contributing to death h	ut not resulting in the u	nderlying cause o	oven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
þ	Part II. Other significant conditio	na continuating to death bi		ndonying dadde g				
ğ	Part II. Other significant condition					1 Tes		bably 4 Unknown
Completed by Physician/Medical	Part II. Other significant condition	ns continuing to death of				1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
Be Completed by	25. Was case referred to medical examiner?]11 -			26. Place of Death	24a. Was an autopsy performed 1 Yes 2	24b. Were autoprior to or death?	opsy findings available ompletion of cause of 2 No
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpatier	nt 3 DOA	ther: 4 🗆 Nursing Hom	24a. Was an autopsy performed 1 Yes 2 Check on one)	24b. Were autoprior to death? 10	opsy findings available ompletion of cause of 2 No
To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No. 27 Manner eath 1 atural 5 Pending	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da)	y 28b. Time o	nt 3 DOA O	ther: 4 Nursing Homury at 2 ork?	24a. Was an autopsy performed 1 Yes 2	24b. Were autoprior to death? 10	opsy findings available ompletion of cause of 2 No
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Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Ne 27. Manner eath 1 atural 5 Pending investig 3 Suicide 6 Could n determi 29a. Certifier Certifying	Hospital: 1 Inpatie 28a. Date of Inju (Month, Day ation of be ned 28e. Place of Inju building, etc	y Year) 28b. Time o Injury 28b. Time o Injury At home, farm, str (Specify)	nt 3 DOA Of 28c. Inju	ther: 4 Nursing Hom uny at ork? Yes 2 No	24a. Was an autopsy performed 1 Yes 2 Check on one) 1 Sescribe how in the Court of the City or Town, Secrible 10 the cause	24b. Were autoprior to or death? 1 Yes e 6 Other (Speciniury occurred t and Number or Runtate)	opsy findings available ompletion of cause of 2 No No No No No No No No No No No No No
edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) ation ot be ned 28e. Place of Inju building, etc	ry 28b. Time of Injury 28b. T	nt 3 DOA Of 28c. Inju Www. 1 Ceet, factory, office	ther: 4 Nursing Hom uny at ork? Yes 2 No time, date and place, a opinion, death occurre	24a. Was an autopsy performed 1 Yes 2 Check on one) are 5 Residence 8d. Describe how in the control of the control of the control of the control of the caused at the time, date	24b. Were autoprior to or death? 1 Yes 6 Other (Special Injury occurred) 1 and Number or Runtate) e(s) and manner as and place, and due to	opsy findings available ompletion of cause of 2 No No No No No No No No No No No No No
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edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) ation ot be ned 28e. Place of Inju building, etc examiner: On the basis of and manner sta	y Year) 28b. Time of Injury	nt 3 DOA Of 28c. Inju WW 1 Ceet, factory, office h occurred at the to vestigation, in my 29c. Licen	ther: 4 Nursing Hom uny at cork? Yes 2 No 2 time, date and place, a opinion, death occurre use number	24a. Was an autopsy performed to the cause dat the time, date	24b. Were autoprior to expendent? 1 Yes e 6 Other (Special Injury occurred) and Number or Runtate) e(s) and manner as and place, and due to the place, and due to the place and place. Date signed (Month, 3/2006)	opsy findings available ompletion of cause of 2 No No No No No No No No No No No No No

				partment of Health and Nertificate of Death		ene g. No. 0 0 6	04912
	Dharini		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		David Marion Skillman	1	February		10:40 P ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			769 Tanglewood Drive	0akland If Under 1 Year If Under 24 Hrs.	T = = ·	Garrett	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 2 M 2 □ F 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	rear) Coun	lace (State or Foreign try)
			Usual Residence of Decedent		APTIL ZI	1945 Washi	ington, DC
	yland how		10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
	e Mar	ctor	MD Garrett Oakla	and			1 ☐ Yes 2X No
	ith th	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
	ath w		769 Tanglewood Drive	21550		United Stat	es
36	be filed within 72 hours after death with the Maryland ital Hygiene. I have a conference of other than "natural", or Itams 23a or 28a-f show event, it e Madical Examiner must be motified at	by Funerai	1 Never Married 2 Married 1 Never Married 2 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify: 	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify:	etc.
21215-0036	tural	edt	1907-1971	edent's Usual Occupation	1	6b. Kind of Business/Ind	ite
15	nin 72	Completed	(Specify only highest grade completed) (Gi	re kind of work done during most of work DO NOT use retired)	king	ob. Killa of business/inc	lustry
212	d with	E O		ified Public Accou	intant	Accounting	
g	e filed al Hygi i othar vent, L	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
yla	2 should be filed within and Mental Hygiene. Is marked othar than aumatic event, Ire Man	2	William Skillman	Mary	Fairbank	s Zuckerm	an
Baltimore, Maryland	2 she and is m			ling Address (Street and Number or Run	al Route Number,	City or Town, State, Zip	Code)
رب ا	and lealth m 27 her tu			Tanglewood Drive,			
0	ges it of the lift its		T Burias 2 Escremation 3 Linemoval from State	ematory or other place)		Oc. Location - City or To-	wn, State
븚	t. Partmer	. 1		ind Crematory 2/11		umberland,	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evoluce.		21. Signature of the rain service cicensee	22. Name and Address of Facility Bur 21 N. Seco		st Funeral Oakland, MD	
П			23a. Party. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician	8 11	Immediate Cause (Final disease or condition assulting in death)	n comes			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	il de week			/ = 4 5
	LAGITITIE	L	Sequentially list conditions, b.				
	bed fist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury that interest and or injury)				
	xecul and al-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	cate be executed obysician and the burial-transit	dical E					
687	ficate p physics the	edic	0.				
O. Box	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	y Day Year
D	s that ned by deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Sp	quires n sign	D D	diabetes wellitus I hypert	encer heardiseas	1 ☐ Yes	2 No 3 □ Proba	ibly 4 DUnknown
Records,	s been si should	Completed by			24a. Was an	24b. Were autop	sy findings available
	The ta	mo			autopsy	prior to comed? death?	pletion of cause of
Vita	rtifica tor, p	BeC	25. Was case referred to medical	26. Place of Deatl	1 ☐ Yes 2 h <i>Check on one</i>	XNo 1 ☐ Yes	2 No
>	nysici nis ce direc	ToB	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpati	Other	. /	ce 6 ☐Other (Specify,)
0	ng Ph tter th		27. Manner of Death Altural 5 Pending (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Di scribe how	injury occurred	
0	vttandin death. ctor: Al y the fu	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	after d Direct J in by I	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	pital purs a aral [29a. Certifier Certifying Physician: To the best of my knowledge deal				
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau red at the time, date	se(s) and manner as sta e and place, and due to	the cause(s)
	To the within 7 To the comple	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, D	
	/ 0		Margaret a Paux 10	026650	2	-10-200	6
5	AVA		30. Name and addless of person, who completed cause of death (Item 23a) (Type Max Packet A Kaisec and 131079 (Print)	outela	1-10-200	26550
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- June	acon acc	1000	
	Registr	ar	FEB 1 0 2006	noch)			

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State of Maryland / Department of Health and Mental	Hygiene	na	O.L.
Certificate of Death	Por No	UU	UH

			1 - State Registrar				rtificate of	Death		leg. No.	6	14913
			1. Decedent's Name (First, M	liddle, Last)					2. Date of Dea	th		3. Time of Death
	Physic /Medi		Dennis	Rav	Swartz	entrubei			Month FEB.	6, 2006	Year	1730 P ^M
	Exami		4a. Facility Name (If not instit			oner abei		r Location of Death	1,110.	4c. County		1730 1
1			3732 SWANTON	J ROAD			SWANTO	J		GARRI		
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Director		213-50-7997	1 M 2 □ F	53	Yrs.	Months Days	Hours Min.	(Month, Day April 8			and, MD
	D.		Usual Residence of Deceder	t					TIPLIT O	, <u>+</u> ////	Oaki	and, m
	arylar show		10a. State 10b. Co	inty	10c.	City, Town or Lo	cation				11	0d. Inside City Limits
	the Maryla 28a-f shor	cto	MD Garı	ett		Swantor	ı					1 ☐ Yes 2 XNo
•	ith the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	What Coun	try?
	death with the Maryland ms 23a or 28a-f show	a C	3732 Swanton	Road						U.S.		
	dea	Funeral	11. Marital Status	12. Was D	ecedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No-	14. Rac	e - Americ	
9	hours after ural', or ite		1 Never Married 2	Married 12 Ye	Forces?				Rican, etc.)		k, White, e	
93	hours tural',	þ	3 □ Widowed 4 🛣 Divo	ced Year o	Give or Dates: Viet	tnam	1 ☐ Yes 2 🙀 No	Specify:		Specify	"Whit	e
9	72 h	Completed	15. Dece	dent's Education ghest grade complete	1	16a. Dece	lent's Usual Occup	ation		16b. Kind of Bu	usiness/Inc	dustry
2	Man e	ğ	Elementary/Secondary (0-1		e (1-4or 5+)	life.	DO NOT use retired	during most of work 1)	ing			
2	og an transfer of	5	12			wor	ker			mining	,	
pu	al H	Be (17. Father's Name (First, Mid	dle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Sumam	18)	
/a	Mental Mental arked o	70	Willard A. Sw	artzentrul	ber			Evelyn	Elsie I	riend		
Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 hc Department of Health and Mental Hygiane Important: If Item 27 is marked other than "natuu any injury or other traumatic event, the Medical ance:		19a. Informant's Name/Relat	onship (Type, Print)		19b. Mailir	g Address (Street	and Number or Rur	al Route Number	, City or Town,	State, Zip	Code)
	and all hall hall hall hall hall hall hall		Richard L. Sw	artzentrul	ber	103 N	. Pond C	t., Green	wood, SO	29649	9	
<u>S</u>	of He		20a. Method of Disposition		20b		sition (Name of natory or other place			20c. Location -	City or To	wn, State
Baltimore,	Page nent nr: If		1X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 ∐Hemoval fro r <i>(Specify)</i>	AII Otate			rch 2/10	/06	Oakland	4 MT	
alt:	mit.		21. Signature of Furieral Sen	rice Licensee	- 00			ss of Facility Bu		Uaktano	I, MD	TT
ä	Depa impo any it		FORME	A 451	udock	,		21 N. Sec				
			23a. Part 1 Enter the disease	or complications the	at caused the de	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est.	ma, r	Approximate
			shoek, or heart failure. Immediate Cause (Final	List only one cause o	n each line.	1 -	,					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ d	moscler		andiou	scular a	disear	ا		
	Examiner			Due	to (or as a conse	equence of):						
		ē	Sequentially list conditions if any, leading to immediate	h. Due	to (or as a conse	equence of):						
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	,							
	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the buriat-transit	xa	that initiated events resulting in death) Last	c	to (or as a conse	equence of):						
68760,	sicia, buri	a										
587	phy:	Medical		d.								
×	certi Iding		IF FEMALE:	23c. If ves.	outcome of preg	nancy						
Вох	eath cer attendin I for use	ciar	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2□Fe egnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver oth	y Day Year
P.O.	the d y the ched	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Un		GOAIII J_	Cirioi (specily)					
٦	res that the de igned by the a be detached f		Part II. Other significant con-	ditions contributing to	death but not re	esulting in the un	deriving cause give	on in Part I.	23e. Did tob	acco use contr	ibute to the	cause of death?
ds	uires sign d be	d b	chronic	alcohol	isho		, ,			s 2 No		V
Ö	w requir been s should	Completed by			,				Grant College			
3e	has has	臣							24a. Was ar autops	у р	rior to com	sy findings available pletion of cause of
<u>=</u>	icien: The l certificate ha ector, page 3								perform 1 XYes 2	IBG? a	eath? AYes 2	2□ No
Z.	ysicien: is certific director,	Be	25. Was case referred to med examiner?	Hospital:			Out	26. Place of Death				
of	Phys this al di	၉	1 X Yes 2 No 27. Manner of Death	11	☐Inpatient 2	-		4 Li Nursing nor				AT SCENE
2	Da 0 0	<u>0</u>	1 Natural 5 ☐ Per	nding (Me	te of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurre	ed	
Sic	ttend death ttor: the	cat		estigation uld not be				res 2 □ No				
Division of Vital Records,	or A lifter Direction by	Certification:	4 ☐ Homicide det	armined 289. Pla	ice of Injury - At Ilding, etc. (Spec	home, farm, stre cify)	et, factory, office	1	28f. Location (Str City or Town	eet and Numbe , State)	er or Rural	Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	- r	20a Coddies and a	t in a particular			7.4.					
	Hos 24 hc Fun fely t	Medical	29a. Certifier 1 ☐ Certifier (Check only 2 ☑ Medical	lying Physician: To to cal Examiner: On the	o basis of examin	nowledge, death nation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and mar	nner as sta	ited. the cause(s)
	thin the mple	Mec		angina	anner stated.							
	₹ ¥ ₹ 8		29b. Signature and title of cert	Ki mi			29c. License	number C.M.E		ed. Date signed FEB. 7,		
				,				, • 11 • 11		۰ ، تنظی	2000	,
	5aV	A	30. Name and address of pers					D 4 T P T 10 T		24-	04	
	Jan		LING	LI, M	(D)	TIT PEN	N STREET,	BALTIMOR	RE,MARYL	AND 212	OI.	

State Registrar 31. Date filed (Month, Day, Year) FEB - 8 2006

111 PENN STREET, BALTIMORE, MARYLAND 21201

		1	For State Registrar	tate of Mary		artment o			Reg	ene () 6	04914
4. 90	Dhusial		Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Louis V	Villiam 7	Chompson				January	31, 2		2:18 A. M
	Examin	400	4a. Facility Name (If not institution, give stree			•	m, or Location				y of Death	
			Washington Adventi				ma Parl			Mo	ntgo	
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M		yrs. last birthday) Yrs.	If Under 1 Y Months Da	ear if Onde ays Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day,) August 2	,1928	9. Birthp Court	place (State or Foreign ntry) ch Carolina
	yland low		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation					1	10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygione. If item 27 is marked other than "natural", or items 23s or 28s-(show or other traumatic avant, the Macilcal Experiment be notified at	Director	District of Columbi	a	Wash	ington						1X Yes 2 No
	ith th	- E	10e. Street and Number			10f. Zip Co			100	g. Citizen of		
	ath w 23e	ra	3001 Bladensburg Ro				018	2.1-1-0.40-	N		ce - Americ	
	ar de	Funeral	TI. Wantar Status	Was Decedent Ever	in U.S. 13.1	Was Decedent f Yes, specify	Cuban, Mexic	oan, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
36	s afte	by F		l □ Yes 2 🗶 No If Yes, Give Year or Dates:		1 □ Yes 2 X	No Specif	fy:		Speci	ty: B]	lack
21215-0036	2 hours	led !	15. Decedent's Education	on	16a. Dece	dent's Usual O	ccupation		16	3b. Kind of 8	Business/In	dustry
212	within 72 ene. then "n	Completed	(Specify only highest grade co	m <i>pleted)</i> College (1-4or 5+)	life.	kind of work de DO NOT use re	o <i>ne auring</i> m etired)	ost of worki	ng			
21	or the	Son	6th grade		Сот	struct				Const		ion
pu	be filed ntal Hygi of other svsnt, t	Be	17. Father's Name (First, Middle, Last) Albert Thompson						Blakney	aiden Suma	me)	
Maryland	2 should and Mer is marke sumatic	2	Albert Thompson 19a. Informant's Name/Relationship (Type,		19b. Mailir	ng Address (St				City or Town	n, State, Zip	Code) 20018
≥	od 2 s lth ar 27 is r trau		Mildred Johnson Tho	(1							ngton,DC.
Je,	tem 27		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name	of !		Date 20	Dc. Location		
9	Pages nent of I ant: if its ary or o		1 Marial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State	George W	-			6,2006	Adelph	i, Ma	ryland
Baltimore,	permit. Page Depertment of Important: If sny injury or 2002.		21. Signature of Funeral Serin Scionsee	Sorts	27	Name and A	ddress of Fac	cility Compar	ny Mortic .N.W.:Was	ians.	Inc.	
	- 98		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the								Approximate Interval Between
S. Land	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Soi	ohc ansequence of):	Sho	che	(9	m Eve) Yv2	0)	Onset and Death
	Examiner		Sequentially list conditions b	Ac	Re	nal	fa	elu	16			
	De sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):		1					
	ate be executed hysicien and he burial-transit	Examine	that initiated events c resulting in death) Last	Due to (or as a co	nsequence of):	0 0	2800	no h	n 4			
760,	ysicien ysicien	calE			•							
68	g phy as the											
Вох	leath certificat attending phy I for use as th	M/ui	23b. Was decedent pregnant	If yes, outcome of p 1□Live birth 2□		∃Ectopic pregn	nancv				ate of deliv	
.O. B	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown		Other (specif					fonth	Day Year
<u>α</u>	s that I ned by e deta	by Ph	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the u	nderlying caus	e given in Pai	rt I.	23e. Did toba	acco use co	ntribute to t	the cause of death?
Records,	w requires been sign should be	edb							1 🗆 Yes	2 X No	3 🗆 Pro	bably 4 Unknown
ecc	as be	Completed							24a. Was an autopsy		prior to co	opsy findings available ompletion of cause of
= H		Co							perform 1 Yes 2		death?	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	vital:			Othor		h (Check only one			
of	Physi this c	၉	1 ☐ Yes 2 📉 No Hosp 27. Manner of Death	1 X Inpatient	2 ER/Outpatie				me 5 Resider			fy)
ü	Jing After fune	ion	1 Natural 5 ☐ Pending	(Month, Day Ye	njury	м 200.	Injury at Work? 1 ☐ Yes 2		284. 2030/100 /107	v mjury oco		
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	8e. Place of Injury		reet, factory, of	ffice		28f. Location (Stre City or Town,		ber or Rur	al Route Number,
Ö	s after al Direct	Certification:	4 Homicide	building, etc. (5	Бресіту)				City of Youri,	State)		
	To the Hospitel or At within 24 hours after of to the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) 1	an: To the best of m On the basis of exa and manner stated	amination and/or in	h occurred at to vestigation, in	the time, date my opinion, c	and place, death occurr	and due to the car red at the time, dat	use(s) and n te and place	nanner as s , and due t	stated. to the cause(s)
	within 2 To the complet	×	29b. Signature and title of certifier				icense numbe			d. Date sign		
	(1)		Chil			D			0 0			
	Il.	7	30. Name and address of person who comp	leted cause of death AHME					Spring, A st; Suit		ind 2	20903
A STATE OF THE PARTY OF THE PAR	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	٠ .						
12.5	2 (1997)	\$ 30 ·	FFR 0 6 2006	The said								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 1 ancil 1408 M lartha February 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F 60 Yrs. 004-50-2747 1/04/1946 Portland, ME Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Derwood 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7125 Mill Run Drive 20855 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Yes 22 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of Customer Rel 5+Amtrak 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Bonney Vivian Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 2 2 2 Philip Simon/ex-husband 36 Stone Ridge Road Drums, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 2/03/06 Beltsville, Md. 4 Donation Other (Specify) 21. Signature ¥ F eral Service Licenses PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Edema 12 Hours Due to (or as a consequence of) Encepalo Hepatic Due to (or as a consequence of): Meta latic Colon Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide

Examiner Hospital or Attending Phyelcian: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. attending physician certificate After this certific funeral director, 24 hours after death. Funeral Director: A Director: /

Physician

/Medical

Examiner

Completed by Funeral Director

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 28s-1 show any njury or other traumatic event, the Medical Examinar must be notified as once.

Physician

/Medical

use as the burial-transit

Baltimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be ၉ Certification: 27. Manner of Death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician D0063088 February, 2nd 2006

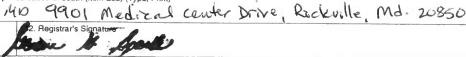
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Mohit 31. Date filed (Month, Day, Year) FEB 0 6 2006

Xashqi



of person who completed cause of death (Item 23a) (Type, Print)

Registrar

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I			giene 0 0 6	04916
	Physic	ian	1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath Day Year	3. Time of Death
	/Medi	cal	Yunbin Tang					Februa		9:20 P M
	Exami	ner	4a. Facility Name (If not institution, give				or Location of Deat	th	4c. County of De	
	Funanci		Montgomery General 5. Social Security Number 6. Se		e (In yrs. last birthday)	Olney If Under 1 Year	If Under 24 Hrs	0.000	Montgome	
	Funeral Director			M 2□F	68 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 9. B	rthplace (State or Foreign Country) China
	ylano now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	B-f-s	ctor	Maryland Montgome	ry	Germanto	wn				1 ☐ Yes 2 🛣 No
	or 28)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	ath w	-ia	20400 Afternoon La	ne		208	374		United Sta	ites
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Example that the notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	lo	Was Decedent of H fYes, specify Cub l□ Yes 21x1 No		pecify Yes or No to Rican, etc.)	- 14. Race - Am Black, Wh Specify: A	ite, etc.
5-0	72 ho natur	Completed	15. Decedent's Ed	cation	16a, Dece	lent's Usual Occup	ation		16b. Kind of Business	s/Industry
2	d 2 should be filed within 'n and Mental Hygiene. 7 Is marked other than "r traumatic event, the Med	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	kind of work done OO NOT use retired	during most of wor d)	rking		
121	led w lygier her th	S	47 5-45-4-11 (5) - 14 (4)	4		Collect			Art	
Maryland	t be fi	Be	17. Father's Name (First, Middle, Last) Bingzhi-Tang						Maiden Sumame)	
Ž	hould d Me mark matic	2	19a. Informant's Name/Relationship (T	ma Drintl				ain-Wu		
Z	id 2 s Ith an 27 is i		Jiahua Qian/ Wife						r, City or Town, State,	
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition		120h Place of Dices	nition /Alama of		Germant	own, MD 20 20c. Location - City or	874
OE.	Pages ment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Metropol Crematori	natory or other place itan_	Febi	ruary	Alexandr	ia,
Baltimore,	artmen oortant: injury		21. Signature of Funeral Service Ucer's	7	Grematori 22	um, Inc.	ss of Facility D	2006 eVol Fur	Virgineral Home,	nia
ä	Depar Impor any ir		MA / H	М00689) 10	East De	er Park	Drive. G	laithershur	g, MD 20877
	Physician /Medical Examiner		23a Part Buler the disease, or compleshoot, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a	the death. Do not ente e. ic Ureters consequence of):	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Lisass of the Causs) that initiated events resulting in death) Last	·	consequence of):					
.O. Box 6	the death certify the attending ched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
ς, σ		by P	Part II. Other significant conditions cor	tributing to death but	not resulting in the un	derlying cause give	n in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ğ	w require been slo should b	ed						1 🗆 Y	es 2 No 3 Pr	obably 4 XUnknown
Records,	e ta has	Completed						24a. Was a autops perform	y prior to o	stopsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	h (Check only on		2□ No
of <	di S	2	1 103 2 110	ospital: 1 🔯 Inpatient	2 ER/Outpatient	3 DOA Othe	_		ence 6 Other (Spec	cify)
Division o	Jing After funer	Certification;	27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work M 1 \(\sqrt{Y}	at		ow injury occurred	,
Σ	ital or Attenders after death ral Director: led in by the	Certifi	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stree (Specify)	et, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemination	ician: To the best of er: On the basis of e and manner state	xamination and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To To Com	Σ	29b. Signature and title of certifier			29c. License	number	25	9d. Date signed (Month	n, Day, Year)
'	0		Pullamen			D-60	335		February 4,	2006
	10		30. Name and address of person who con Paul Bannen, M.D.,			rint)				
	Stat Registra	e	31. Date filed (Month, Day, Year) FEB 0 6 200					- 1		

			1 - For State Registrer	State of Ma	aryland / Depa <i>Ce</i>	artment of F			giene 0 0 6	04917
	Discorter		1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Frank	Trotto,	Jr.			Februar	y 5, 2006	5:40 P M
	Examir	ner	4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, o	r Location of De	ath	4c. County of Death	
			Fort Washington	Hospital			shingto		Prince Ge	
	Funeral Director			Sex 7.Ag 1.□XM 2.□F	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	Hours Mi	n. (Month, De)	h 9. Birth Cou	plece (State or Foreign intry)
			235-40-4271 Usual Residence of Decedent		74			Septemb	er 11,1931	West Virgin
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-fs	ctor	Maryland Prince G	eorges	Fort Was	nington				1 ☐ Yes 2X☐XNo
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
	ath w	ral	100 River Forest			20744			USA	
	er de Items	une	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race - Ameri Black, White	
36	rs aft	y F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 1 If Yes, Give Year or Dates:	60	1 ☐ Yes 2XDX No	Specify:		Specify: Whi	te
9	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant. The Medical Examinat must be troutiled at	Completed by Funeral	15. Decedent's E	L		dent's Usual Occup	ation		16b. Kind of Business/Ir	ndustry
215	hin 7.	pie	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of w	-		
21	d with	E	Contentary/Gecondary (0-12)	5+	Denti	st			Self-Employ	ed/Healthca:
pg	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last,)			18. Mother's N	ame (First, Middle,	Maiden Surname)	
yla	Ment Ment arke	ပ	Frank	Trotto,	Sr.		Beatri	ce	Palotta	
Maryland 21215-0036	2 sh and is m raum		19a. Informant's Name/Relationship (r, City or Town, State, Zij	
e)	1 and lealth sm 27 ther t		Elisabeth Trotto - 20a. Method of Disposition	- Wife	20b. Place of Dispo		st Lane	, Ft. Was	hington, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. The Medical Esantinet must be notified at ODGs.		1 ☐ Burial 2 🖾 Cremation 3 ☐		cemetery, crer	natory or other plac			20c. Location - City or T	
를	it. Partiment injury		*4 □ Donation 5 □ Other (Specifical Septice Licer		Kalas Cre		Febru	ary 7,200	6 Edgewater	, MD
Ba	Department of the position of		Plant II list	7	Ğ	eorge P.	Kalas F	uneral Ho	me, P.A. i11, MD 207	, ,
			23a. Part. Epter the disease, or com	plications that ceused	the death. Do not enti-	er the mode of dvin	D. such as cardi	UXOΠ H ac or respiratory arr	rest.	45 Approximate
	Physician	y 7	Immediate Cause (Final	one cause on each lin	10.		•			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as:	a consequence of):	ala_	3			
ı	Examiner		Constant to the first one of the con-	Charm	in The	Luct		2000	disa	
	D H	iner	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).				Coto made	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physician and the burial-transit		tooding in dodn't begin	Due to (or as	a consequence of);					
387		dicai		_ d						
ŏ	eath certif attending for use as	an/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of delive	00/
ă	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊡Live birth 4⊡Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			Month	Day Year
o.	the cachec	hys	9 Unknown	9□ Unknown						
S, D	res that the de signed by the a be detached t	by Physici	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
ğ	w require been sig should b		Melastata	(SIX	cinon	10		1 □ Y	es 2 □ No 3 □ Prot	pably 4 Unknown
Record	aw re	Completed	Desholo:	11008	illen			24a. Was a	n 24b. Were auto	ppsy findings available impletion of cause of
	sician: The law certificate has b irector, page 2 s	E	Ity has Asi		(autops perform	med? prior to co med? death? 2 ☑ No 1 ☐ Yes	
Vita	ian: artifica ctor.	Bec	25. Was case referred to medical examiner?	3(00)			26. Place of De	ath (Check only on		2010
	Attending Physician: r death. ector: After this certific: by the funeral director.	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		1 3□ DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Reside	ence 6 □Other (Specif	(y)
בֿ	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	ow injury occurred	
Division of	Vitendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	-		
\leq	of or Attending Frater death. I Director: After I din by the funera	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	ry · At home, farm, stre . (Specify)	et, factory, office		28f. Location (Si City or Town	treet and Number or Rura n, State)	al Route Number,
_	pital		29a. Certifier TV Certifying Ph	veician: To the best of	f my knowledge, death	and the time	o data and slav	a and due to the co	ause(s) and manner as s	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 1	Medical	(Check only one)	niner: On the basis of and manner sta	examination and/or inv	estigation, in my op	oinion, death occ	urred at the time, d	ause(s) and manner as s ate and place, and due to	the cause(s)
	ro the ro the compli	Me	29b. Signature and title of certifier	4		29c. License	number	2	9d. Date signed (Month,	Dey, Year)
	(10)		> Men_	all A	Kendiny	D)	1402	0	2/6/0	6
	000		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, I	Print)				i < 10
_	ع وه		MOTIL KO	ULM.	D 44	67 of	al Bri	auchAir	e Templ	e hills
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature				Ċ	NG 20198
	Registr	ar	FFB 0 7 2006 A	1						

			For State State Registrar	of Maryland / [Departmer <i>Certificat</i>				ene	6	04918
			Decedent's Name (First, Middle, Last)					2. Date of Death		V	3. Time of Death
	Physici /Medic		RHODA EUGENA TRITAPO	E			F	ebruary	07, 2	2006	2:00 am [™]
	Examir		4a. Facility Name (If not institution, give street and REEDERS MEMORIAL HOME	number)			NSBORO		4c. County		HINGTON
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 🔏 F	7. Age (In yrs. last bird	thday) If Unde Months		nder 24 Hrs. surs Min. D	B. Date of Birth (Month, Day, EC. 20,	1903	9. Birthp Cour MA	place (State or Foreign http) ARYLAND
224	and		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					1	Od. Inside City Limits
\$	er death with the Marylar Items 23a or 28a-f show her must be collified at	Funeral Director	MARYLAND WASHINGTON	J		OONSBOR	.0				1X Yes 2□No
ğ	with t	Dir	10e. Street and Number 141 S. MAIN STREET		10f. Zip	217	1 2	10	g. Citizen of		1
\propto	Jeath ms 23	era	11. Marital Status 12. Was Do	ecedent Ever in U.S.	13. Was Dece			ity Yes or No-	14. Rac		S.A.
0036	tiled within 72 hours atter death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be molified at	by	1 Never Married 2 Married 1 Ye	Forces? s 2 X No	If Yes, spe		c Origin? (Speci xican, Puerto Ri ocify:	can, etc.)		ck, White,	etc.
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade complete	d) 16a.	Decedent's Usu (Give kind of wo	rk done during	most of working	11	6b. Kind of B	usiness/Inc	dustry
35	within ne. ihan	Completed		(1-4or 5+)	life. DO NOT u	se retired)				OTTAT T	TOME
0 2	tiled v Hygie ther t		O 17. Father's Name (First, Middle, Last)		П	OMEMAKE 18. M		First, Middle, Ma		OWN H	OME
Ylan	2 should be tiled within and Mental Hygiene. Is marked other than aumatic event, the Man	To Be	OLIVER MELVIN COLUMBUS			E	MMA HOF	FMAN			
Mar	s 1 and 2 should be tiled within 72 hd if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		19a. Informant's Name/Relationship (Type, Print) JAMES L. TRITAPOE, SON	3	704 ROH	RERSVIL					21715
ore	Pages 1 nent of He int: If Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro		Disposition (Nar y, crematory or o	ne of ther place)	Dat		Oc. Location	City or To	wn, State
Baltimor			`4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → vyeral vice → page 6	BOONS	BORO CEI		2/10/20				MARYLAND
) Qume Baltin	permit. Departr Imports any inj		21. Signature Video and Vi			d Address of F FUNERA		7606 OLI BOONSBOI			
2			23a. Part1. Enter the disease, or complications that shock, or feart failure. List only one cause or	t caused the death. Do n							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumon	19						Onset and Death
	/Medical Examiner		resulting in death) Due 1	o (or as a consequence of	-						
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,0	cate be executed physician and the burial-transit		resulting in death) Last Due t	o (or as a consequence o	of):						
8760,	the the	dicai	d								
9	n certitii anding j use as	0	23b. Was decedent pregnant	outcome of pregnancy	205	*			23d. Da	te of delive	iry
O. B	the death y the atte	Physician/M		e birth 2 ☐ Fetal death gnant at time of death known	3 ⊟Ectopic pa 5 □ Other (sp				Мо	nth	Day Year
JS, P	ires that signed b	þ	Part II. Other significant conditions contributing to	death but not resulting in	the underlying o	ause given in P	art I.	23e. Did toba		ribute to th	ne cause of death?
Sorc	v requ	etec	Periphal va	20.100	N. 1. 10 1.				^		
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours atter death. To the Funeral Director: Atter this certilicate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed	Jen pma vo	schur	giscus			24a. Was an autopsy performe	ed?	prior to cor death?	psy findings available npletion of cause of
Vita	sician	Be	25. Was case referred to medical examiner?			Other		Check only one)			
of	Phys er this eral di	. To	27. Manner of Death 28a. Dat	e of Injury 28b. T		8c. Injury at	1	5 Residen			<u>') </u>
ion	nding ath. r: Atte e fune	atior	1 XNatural 5 ☐ Pending (Mo 2 ☐ Accident investigation	onth, Day Year) In	jury M	Work? 1 ☐ Yes 2			. ,		
ixis	or Atterder der irecto	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, far Iding, etc. (Specify)	m, street, factory	, office	281	Location (Stre City or Town,		er or Rura	l Route Number,
۵	pital o		29a. Certifier 1 Certifying Physician: To t	he heat of my keep landers	de able and a de			d d	(-)		
	e Hos 24 hc e Fun letely	edicai	(Check only 2 Medical Examiner: On the	basis of examination and anner stated.	Vor investigation	in my opinion,	death occurred	at the time, date	se(s) and ma e and place,	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature an Atitle of certifier			. License numb		290	I. Date signe		
			1000		1	1499	ь	\mathcal{F}	eb 7	, 200	06
0 6/	1-2	IJ	30. Name and address of person who completed ca		* .	chana	MD 2171	2 201	432-84	70	
	Sta	e.	Dr. Zafar Malik, 20311 31. Date filed (Month, Day, Year) 32.	Lappans Roa Registrar's Signature	iu, boon	sporo,	מוט בו/1	2 201-	734-04	7.0	
	Registr	-	FER 0.8 2006	A. A.	Both State	•					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ernest Wilhelm Thompson 1155 rebulan 6 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year **Funeral** Birthplace (State or Foreign Country) 1**⊠**M 2□F 373-28-0783 75 Yrs Director Dec. 12, 1930 Michigan Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 28a-f show 10d, Inside City Limits the Mudical Examiner must be notified at Maryland Washington 1 X Yes 2 □ No Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1437 Church Street 238 21740 USA death Funeral tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene and Herlath and Tarmarked other than "natural, or then any or other traumatic event, the Medical Expans any or other traumatic event, the Medical Expans any 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 clergyman church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Thompson Viola Holdorph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucile Janet Thompson - wife 1437 Church St., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 2/10/06 Hagerstown, Maryland 21. Signature of Funerat Service Licenses hame and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on rain line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 D Fetal death for 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. the 9□Unknown Part II. Other significant conditions contributing to dealth but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Watural 5 Pending Injury after death. investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D27898 completed cause of death (Item 23a) (Type, Print) HAGERSTONA ANDRADE FRANCISCO 350 MILL ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 07 Registrar

			1- For State of Maryland / I			lental Hygie	ene 2006	04920
	Dhyoioi	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		ALBERT WARREN THOMPSON				23 2006	7:10PM ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Deati	
			Genesis HealthCare - The Pin 5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Iston If Under 24 Hrs.	8 Date of Birth	Talbe	
	Funeral Director		1 9 N 20 5	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
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25	shov a p	5	10a. State 10b. County 10c. City, Tow				;	10d. Inside City Limits 1 ☐ Yes 2 No
death with the Maryland	28a-	Director	MD TALBOT EASTO 10e. Street and Number	N 10f. Zip Code		100	g. Citizen of What Co	
with	3a or	0	29266 W. KENNEDY STREET	21601		"	USA	y.
	ems S	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe		14. Race - Amer	
OU36	or th	by Fu		1 ☐ Yes 2X No	Specify:	rucari, etc.)	Black, White	WHITE
5-0036	n "netural", or items 23a or 28a-f show ballcal Evaniner must be notified at			. Decedent's Usual Occup.	ation	46	Sb. Kind of Business/I	
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Z Z Z Z		Completed	10 W	ATERMAN			SEAFOOD	
and 2	× 2 2	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
S	nd Ment marked imatic	2		M 311 (2)		IA CROUCH		
Ma	f Health and Mer Item 27 is marke other traumatic			266 W. KENNE				ip Code)
5	f Hea item other		20a. Method of Disposition 20b. Place of	f Disposition (Name of			c. Location - City or 1	Town, State
altimor	partment of sortant: If it it injury or o		Togothal 2 Cremation 3 Chemoval from State	ry, crematory`or other plac ISVILLE CEMET	.	/2006	STEVENSVIL	LE. MD
	Departrumborts any inju		21. Signature of Funeral Service Licensee	22. Name and Address FELLOWS, H 106 SHAMRO	ss of Facility			
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The law requires that the death certificate be executed	been signed by the attending pl should be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	very Day Year
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The	page	Com				performe		2□ No
VICIEN: T	ector,	Be	25. Was case referred to medical examiner?		26. Place of Death			
2 g	rthis (: To	1 Inpatient 2 ER/Ou		4 Nursing Hor	me 5 Residence 28d. Describe how	ce 6 ☐ Other (Specialismus) ecourred	rfy)
Attending	th. : Afte. s fune	tlon		njury Work	k? Yes 2 □ No	EDG. Describe now	injury occurred	
Atter	er dea ector by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa	rm, street, factory, office		28f. Location (Stree	et and Number or Rui	al Route Number,
2 💆	rs aftered Dir	Cert	4 Homicide building, etc. (Specify)		1	City or Town, S	siate)	
DIVISION OF VICE To the Hospitel or Attending Physicien:	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge Continuous Physician: To	e, death occurred at the time d/or investigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
Tot	To 1	M	29b. Signature and title of certifier	29c. License	77.59	29d	Date signed (Month)	
			30. Name and address of person who completed cause of death (Item 23a)		1000	1=0-	101 MA	
	Cto	10	31. Date filed (Month, Day, Year) 320Registrar's Signature	DUTCHMAN	> HIINE	415	100 111D	21601
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 2 5 2006 32 Registrar's Signature	A 10.				
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Albert Thompson

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JOSEPH JOHN THOMPSON JANUARY 29, 2006 10:10 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 800 MONROE MANOR ROAD STEVENSVILLE **OUEEN ANNE'S** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 ☐ F Director 579-20-9716 Yrs 79 MAY 29, 1926 NY Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heath and Mental Hygiene.
ant: If Itam 27 is marked othar than "natural", or Itams 23a or 28a-f show ury or othar traumatic evant, the Madical Exaturar must be notified at 28a-f show 10d Inside City Limits Director 1 ☐ Yes 2 X No OUEEN ANNE'S MD STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 MONROE MANOR ROAD 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 XYes 2 □ No 1944— If Yes, Give Year or Dates: 1946 Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE ð Specify: 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 FTREMAN PUBLIC SERVICE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First Middle Maiden Surname) JOSEPH THOMPSON 2 MYRTLE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE LEE THOMPSON/WIFE 800 MONROE MANOR RD., STEVENSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) BROADCREEK CEMETERY 02/01/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 penn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARENO OF UNKNOWN ORGIN CARGINOMA disease or condition resulting in death) ZYRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of). Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical use as ed by the attending godetached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 3 Probably 4 Unknown director, page 2 should Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 **1**0 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending death. after death 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \(\text{Homicide} \) within 24 hours a To tha Funaral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D08118 de Unn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOO BEST GATE NO ANN mo STANLEY WATKINS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Elsen & Sperte

State of Maryland / Department of Health and Mental Hygiene 04922 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** TILGHMAN TRENE 5. FEB 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO DEER'S HEAD HOSPITAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 8, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 220-10-9585 89 Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or itema 23a or 28a-i show runer roust be notified at 1 ☐ Yes 2K No Salisbury Maryland Wicomico Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA death Funeral 6057 Hobbs Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced White "natural", Completed ine Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 10 t of Health and Mental Hygis If Item 27 is marked other or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Grav Frank Strush ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6057 Hobbs Rd. Salisbury, Maryland 21804 Nancy Bridge/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a, Method of Disposition Wicomico Memoriai 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 2/8/06 Salisbury, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral St Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 CFSP Mongood 23a. Párt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE RENAL DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (UI as a consequence of) Examine PULMONARY FIBROSIS The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760, HYPERTENSION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š Cerebro vascular Disease 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tyes Be Completed Coronary Artery Discuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Peptic Ulcer Disease 2□ No 1 Tyes Hospital or Attending Physician: certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending м 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier MEDICAL DIRECTOR lark Mones MD MARYLAND D47173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DETERS HEAD HOSPITAL CENTER, SALISBURY, MD 21802 CLARK A. MORRES, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1- For State of Maryland / Department Certification	ent of Health and Me ate of Death	ntal Hygien	11116 Hb47.5
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joseph George Thomas	Fε	Date of Death Month Druary	3. Time of Death 4:00A M
	Examir Funeral Director	er	12435 Shiloh Church Road M	ity, Town, or Location of Death It. Victoria Ider 1 Year If Under 24 Hrs. 8 Bays Hours Min. Ma	Date of Birth (Monut. Day, 398	c. County of Death Charles 9. Bitthplace (State or Foreign Country Marry Land
	Aaryland f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Charles Mt. Vict	oria		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the A 3a or 28a-	I Direct		Zip Code 20661	10g. C	Citizen of What Country?
900	ours after death	d by Funeral Director	1 Never Married 2 N Married 1 Yes 2 No	peedent of Hispanic Origin? (Specif specify Cuban, Mexican, Puerto Ric s 2 No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
121215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Itia Mudical Expuritment inset be notified at	Completed		Isual Occupation work done during most of working T use retired) Driver 18. Mother's Name (i)	St	Kind of Business/Industry
Maryland	2 should be fi and Mental H Is marked ot raumatic ever	To Be	Hillary J. Thomas, Sr.	Annie E.	Hill J	·
Baltimore, Ma	ages 1 and 2 ant of Health a at: If item 27 is y or other trai		Ollie Thomas/Wife 12435 S 20a. Method of Disposition 1 SyrBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (cemeterly, crematory)	hiloh Church Name of or other place) Date	Rd. Mt.	Victoria, MD Location - City or Town, State
Baltir	permit. Pages i Department of H Important: If ite any injury or of once.		21 Signature of Funeral Service Licensee MOOO/5 22 Name	Cemetery 2/9 and Address of Facility HART-ECHOLS F BOX 567 LA	UNERAL	sue,Maryland HOME,P.A.
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the neshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound to Due to (or as a consequence of):		espiratory arrest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic department of the pregnant at time of death 5 Other	c pregnancy (specify)		23d. Date of delivery Month Day Year
<u>α</u> ,	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlyin	g cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,		e Completed	25. Was case referred to medical	26. Place of Death (c	24a. Was an autopsy performed? 1 Yes 2 N	
Division of Vi	anding Physici ath. r: After this ce te funeral direct	Certification; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Xsuicide 6 Could not be	DOA Other: 4 Nursing Home 28c. Injury at Work? 1 Yes 2 No S	5 v esidence d. Describe how inj hot sel:	f with gun
Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certif	29a. Certifier (Check only one) Check only one) 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify) Home 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify) Home 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	ed at the time, date and place, and	2435 Sh.	and Number or Rural Route Number, it is in the church Rd. Oria MD 20661 (s) and manher as stated. Ind place, and due to the cause(s)
)	To the within To the comple	Mec	29b. Signature and title of certifier Mullin M. Tagari M.	29c. License number D0050883		bruary 6,2006
	d34		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yahia M. Tagouri, M.D. 11655 Winesa	app Place, La	Plata,N	MD 20646
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 7 2006			

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155	The state of		Decedent's Name (First, Middle, Last)	2. Date of Death		7 0	3. Time of Death
	Physic /Medi		Charles L. Thomas	Februar	y 1, 2	006	5:50 P. M
1	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County	of Death	
	Funeral Director		Larkin Chase Nursing Center Bowie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 215-26-3409 1⊠M 2□F 75 Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, NOV. 13,	Prince 1930	9. Birth	orges place (State or Foreign ntry) nington, DC
	yland now		10a. State 10b. County 10c. City, Town or Location			1	IOd. Inside City Limits
	e Mar la-fal	ctor	Maryland Anne Arundel Gion Burnie G.	len Burn	ie		1√2 Yes 2 □ No
	vith th	Dire	10e. Street and Number 10f. Zip Code	10	g. Citizen of \	What Cou	ntry?
	eath y	era	213 Royal Arms Way 21 061 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	-4 V	USA		
215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has not seen and Mental Hygiene item 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic evant, it a Madical Examination is	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No Army If Yes, Give Year or Dates: 1952–54	Rican, etc.)		ck, White,	ean Indian, etc. .ack
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working)	1	6b. Kind of B		
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d 21	ould be filed within I Mental Hygiene. Parkad other than latic evant, Ir.e.M.		12th Service Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name	(Eiret Middle M		red.	Covt.
Maryland	ld be ental kad o	To Be	Garage miles	rah Jack:		10)	
ary	2 should and Men Is marka aumatic	-	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rura</i>			State, Zip	Code)
	1 and 2 Health a em 27 ls		Maureen H. Thomas / Spouse 213 Royal Arms Way Gle			2106	
altimore,	m 0 == =		1 XBurial 2 Cremation 3 Demoyal from State cemetery, crematory or other place)	ate 2	0c. Location -	City or To	own, State
Ě	oit. Pages ertment of I ortant: If its injury or or		`4 Donation 5 Other (Specify) MD Veterans Cemetery 2-7-	06	rownsv	ille	, MD
Bai	pernit. Pag Dep rtment Important: I any injury o once.		William N. 12 WXT 8/1 6512 NW Crain Hwy.	ll Funer Bowie,	MD 20	e 715	
	Fnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Ather of the condition resulting in death)	r respiratory arres	st,	и	Approximate Interval Between Onset and Death
8760,	ate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				y for &
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Dat	e of delive	ry Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus	23e. Did toba	10		e cause of death?
Vital Records,		Completed		24a. Was an autopsy performe	ed2 G	rior to cor leath?	osy findings available inpletion of cause of 2 No
Vite Vite	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No.				
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	tlon; To	Nursing Hom	ne 5 Residen 8d. Describe how			')
Divis	tal or Atten s after deat al Diractor: ed in by the	Certification;	3 C Suicido 6 Could not be	8f. Location (Stre City or Town,	et a <i>nd Nu</i> mbe State)	er or Rura	l Route Number,
	he Hospital in 24 hours a ihe Funeral D pletely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, at 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cau d at the time, date	se(s) and mai e and place, a	nner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number 29c. License number		Date signed		Day, Year)
,	(10)11			•	2/2/0	76	
1	U IVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 1-300 Gallant Fox Ln. Suite 22	22 Bow	ie, MD.	207	15
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2006 22. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene () ()

			1 - State Registrar	,	Certificate of Death	Reg		04923
	Physic	ion	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	/Medi		STEPHEN PHILLIP U	TENDAHL, SENIOF		FEBRUARY	04, 2006	11:16P M
1	Exami	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	h	4c. County of Dea	
AC.	£		SOUTHERN MARYLAND 5. Social Security Number 6. Se		CLINTON birthday) If Under 1 Year If Under 24 Hrs		PRINCE	
	Funeral Director			7. Age (In yrs. last	Yrs. Months Days Hours Min.	(Month, Day, Yo	ear) Co	thplace (State or Foreign ountry) SHINGTON, D
	land ow		10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
	Mary F-f sh	to	MD PRINCE G	EORGES TEMP	LE HILLS			XXYes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code	10g	Citizen of What Co	ountry?
	23a		4814 ABBOTT DRIVE		20748		UNITED ST	ATES
	er de de litems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23a or 28a-f show event, Ite Modical Exerting must be notified at	by F	1 ☐ Never Married ②☐XMarned 3 ☐ Widowed 4 ☐ Divorced	1XXYes 2□No9/28/ If Yes, Give Year or Dates: 1/07/	7 /-		Specify: BL	
21215-0036	2 hou		15. Decedent's Edu	cation 1	Sa. Decedent's Usual Occupation	161	o. Kind of Business/	Industry
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Maryland		Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai	•	
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<u>S</u>	12 c		DARLENE UTENDAHL			IPLE HILLS		
ē,	一工る芸		20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other place)	_	. Location - City or	
Ē	Pages ment of ant: If it		MBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	NGTON NATIONAL CEM. 2	2/13/06 S	UITLAND,	MD
Baltimore,	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licens		22. Name and Address of Facility MARSHALL'S FUNERA	L HOME OF	MARYLAND	, INC.
			23a. Part1. Enter the disease, or compl	cations that caused the death. D	4308 SUITLAND ROA to not enter the mode of dying, such as cardiac		AND, MD 2	Approximate
	Physician		shock or heart lailure. List only or Immediate Cause (Final disease or condition	ie cause on each line.				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequent	IAL INFARCTION e of):			20 MINS
	Examiner		Sequentially list conditions.	ANAPHYLACTIC		S		72 HRS
	ted Isit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	·			
•	be execute sician and burial-tran	Examln	that initiated events resulting in death) Last	END STAGE REN Due to (or as a consequence				02 WKS
08/00	s be e sician	alE		, , , , , , , , , , , , , , , , , , , ,			10	
200	ertificate ling phys ie as the	edlcal						
XOX	Physicien: The law requires that the death certificate be executed this certificate hes been signed by the attending physician and at director, page 2 should be detached for use as the burial-transit	₹	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	Ab. 0 () 5		23d. Date of deli	very
מ	requires that the death c been signed by the attenc hould be detached for us	Physician	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
<u>.</u>	d by t	Phy	9 Unknown				1	
Ś	signe signe	þ	Part II. Dther significant conditions con		in the underlying cause given in Part I.			The cause of death?
Records,	been should	Completed	MALIGNANT HYPERTE	NSTON		1 Tes	2UN0 3UPR	bably XX Unknown
ě	The law ate hes b page 2 s	ldm	MORBID OBESITY			24a. Was an autopsy performed	prior to c	lopsy findings available completion of cause of
_	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical			1□ Yes XX	No 1 ☐ Yes	2 No
>	Physicien: r this certific ral director,	OB	examiner?	ospital:	Other	th <i>Check only one</i> ome 5 🗆 Residence	a (70) to	
ō	ng Ph	L:u	27. Manner of Death		. Time of 28c. Injury at	28d. Describe how in		uty)
SION	endin sath. or: At	atlo	XXNatural 5 Pending investigation	(Monal, Day 16al)	Injury Work? M 1 Yes 2 No			
<u> </u>	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	larm, street, factory, office	281. Location (Street City or Town, St	and Number or Ru	ral Route Number,
	pital ours a leral [29a. Certifier XiX Certifying Phys	icing. To the best of a day and a				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)	er: On the best of my knowled er: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the vithir comp	Me	29b. Signature and title ol certifier	10-	29c. License number		Date signed (Month	, Day, Year)
)	(10)		Kooney J.	Wy m	> 100071370	9	15/06	8
	CAR		30. Name and address of person who con					
10	25		RODNEY ELLIS, M.D		BELT ROAD #104 LANE	IAM, MD 207	/06	
	Stat	(C) 1	31. Date liled (Month, Day, Year)	32. Registrar's Signature				

State

Registrar

FEB 0 7 2006

			1 - For State Registrar		aryland / Dep <i>Ce</i>		of He	ealth a		ental Hyg	_		4928
			Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			1	2. Date of Dea			3. Time of Death
	Physici	an								Month	Day	Year	10:47 рм
-	/Medic		AUSTIN EUGENE WI							January			
7	Examin	er	4a. Facility Name (If not institution, give			4b. City, T	lown, or l	Location o	of Death		4c. County of	r Death	
			4105 Landgreen S			Rock			0.4 Um		Montg		
	Funeral		5. Social Security Number 6. Se	7. Ago M 2□F	e (In yrs. last birthday) 73 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day July 1,	Year)	9. Birthpla Counti 1ary L	ace (State or Foreign
	Director		217-20-0700		7.5 115.					July 1,	1932	aryı	and
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation						10	d. Inside City Limits
	sho	ö											1 X Yes 2 No
	he N	ect	Maryland Montgome	ry	Rockville		0 1:				ton Oliver of W		
	With the same of t	ä	10e. Street and Number			10f. Zip					10g. Citizen of W	nat Counti	ry :
	ath v	Funeral Director	4105 Landgreen S				0853				U.S.A.		-1-4
	tams tams	nue	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decede If Yes, speci	ent of His ify Cuban	panic Ori , Mexican	gin? (Spa i, Puerto	cify Yes or No- Rican, etc.)	14. Hace Black	 America White, et 	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 X Divorced	1 X Yes 2 ☐ N If Yes, Give	No l	1 ☐ Yes 2	™ No	Specify:			Specify:	Whit	t o
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-1 show ha Medical Evariater mat be routhed at	d b		Year or Dates:	1 10 5	1 -4 11 1				F	101 101 1 1 1 1		
쟌	nat dig	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual kind of work DO NOT use	k done di	uning most	t of worki	ng	16b. Kind of Bus	iness/indi	ustry
12	withir ne. hen	E	Elementary/Secondary (0-12)	College (1-4or 5	i+)						II C C		
2	tygie tygie her i	ပိ	17. Father's Name (First, Middle, Last)		IIan	sporta					U.S. Gov Maiden Sumame		ient
E C	be fi	Be		-								,	
3	ould Merka Marka	2	Austin Thomas Wi							Irene B			
Maryland	2 st and Is n raun		19a, Informant's Name/Relationship (T)								r, City or Town, S		20032
	lealth m 27 har t		Douglas E. Wiles	- Son				ia Ci		, Apt.	406, Roc		
9	ges 1 I of H If ita or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Disposemetery, cre	matory or oth	her place)		ale	20c. Location - C	ALLY OF TOW	wii, State
<u>=</u>	Pag men ant: jury		* 4 □ Donation 5 □ Other (Specify)		Fort Linc					2006	Brentwoo	d, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f show any Injury or other traumatic avant, the Medical Evantinet must be notified at anose.		21. Signature of Funeral Service Linears	99	2	2. Name and	d Address	of Facilit	y Gas	ch's Fu	neral Ho	ome,	P.A.
Ш_	9.07 F # 91		mackey 1. F.	ur -	4	739 Ba	altir	nore	Aven	ue, Hya	ttsville	, MD	20781
		-	28a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lir	the death. Do not en	ter the mode	of dying	, such as	cardiac c	r respiratory an	rest,		Approximate Interval Between
	Physician ¹		Immediate Cause (Final disease or condition	Congesti	ive Heart 1	Failur	-ρ						Onset and Death Years
	/Medical		resulting in death)	o	a consequence of):	arrar							Teals
	Examiner		Conventially list conditions	Coronary	Artery D:	isease						15	5 Years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
	cutec nd ransi	Examiner	that initiated events	c									
ó,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):								
760,	e ys	icai		d									
89	tifica ng ph as th	led											
Вох	leath certifica attending ph I for use as th	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		∃Ectopic pre	ananav				23d. Date		•
	death certifica e attending ph id for use as th	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at		Other (spe					Mont	h [Day Year
0	that the death led by the atter detached for o	Physician/Med	9 Unknown	9□ Unknown									
s, P	requires that the een signed by th nould be detache	ру Р	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	inderlying ca	iuse givei	n in Part I.		23e. Did to	bacco use contrib	oute to the	cause of death?
ĕ	quire in sig uld b		Chronic Obstruc	tive Pulm	nonary Dise	ase				1 □ Y	es 2∭No 3	B ☐ Proba	bly 4 Dunknown
00	> 0 0	iet								24a. Was a		ere autop:	sy findings available
Re	9 L 9	Completed								autop: perfor	med? de	ath?	pletion of cause of
Vital Record	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes]Yes 2	: 140
\equiv		OB	avaminar?	Hospital:	nt 2 ☐ ER/Outpatie	nt 3 DO/					ence 6 □Other	(Specific)	
of	Phys rrthis sral di	 	27. Manner of Death	28a. Date of Injur (Month, Day			Bc. Injury Work	at			ow injury occurre		
OU	iding Ih. Ih. After funer	tio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year) Injury	М		? es 2.∐.l	No				
S	or Attending after death. Diractor: After In by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, st	reet, factory,	office		1		treet and Number	or Rural	Route Number,
Division	after Dira	Certification:	4 Homicide determined	building, etc	c. (Specify)					City or Tow	n, State)		
	Hospital 24 hours a Funaral I		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, deal	h occurred a	it the time	e, date an	d place, a	and due to the c	ause(s) and man	ner as sta	ted.
	e Ho 24 h a Fu	edical	(Check only 2 Medical Exam one)	ner: On the basis of and manner sta	f examination and/or in ated.	vestigation,	in my opi	inion, dea	th occurr	ed at the time, o	late and place, ar	nd due to t	the cause(s)
	To the Hospital or Attenwithin 24 hours after deat Yo tha Funaral Diractor: completely filled in by the	Me	29b. Signature and title of certifier			29c.	License	number		2	29d. Date signed	(Month, D	ay, Year)
	Fix		DO Co	00	mo	T) 2:	344.	2		February	<i>7</i> 6	2006
	(10)		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type		- 33	7 1.			Lebruar	, 0,	2000
	960		Alan R. Pollack		, , , , , , , , , , , , , , , , , , , ,		ad. '	Ste	111	Rockvi	11e. MD	2085	4-2957
	Sta	te	31. Date filed (Month, Day, Year)	32. Redistra	ar's Signature	100			والما	2100101	اللبد وحد	_=	
	Registi		FEB 0 7 2006	The same	1								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:35 AM February 6,2006 Richard Swain Webster /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Salisbury Wicomico 312 N. Kaywood Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 10,1930
Maryland Birthplace (State or Foreign Country) 6 Sax 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F 75 Director 215-26-5218 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 238 c USA 312 N. Kaywood Drive 21804 deeth y Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. e filed within 72 hours after if Hygiene. other than "natural", or Ita 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor 12 treumatic event, 18 Mother's Name (First Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) Lena Ellen Owens David Swain Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 312 N. Kaywood Drive, Salisbury, Maryland 21804 Virginia Webster/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2/10/06 Salisbury, Maryland Park 22. Name and Address of Facility Holloway Funeral Home P.A. CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bet interv Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 mi do /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examiner burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death P.0. be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Tyes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificant 25. Was case referred to medical 26. Place of Death (Check only o Be examiner Other: 4 Nursing Home Hospital: 5 Sidence 6 □Other (Specify) ျှ 1 Yes RNO 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Sescribe how injury occurred funeral 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and the of 29d. Date signed (Month, Day, Year) 29c. License number certifier son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p APRIL ST NASSD 145 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 7 Registrar

			For State Registrar	State of	Marylar		artmen rtificate					jiene (06	04930
	Physici	an	1. Decedent's Name (First, Mid Richard			Ward					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media	cal		James	arl .	waru	4h Cih.	Ta	Lagation		Februar		2006 unty of Death	8:00A M
	Examir	ier	4a. Facility Name (If not institution 20716 Crystal			. + E	_ `		Location	or Death				
	Funeral		5. Social Security Number	6. Sex 7.		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	1	1tgome1	place (State or Foreign ntry)
	Director		046-44-2090	1½ M 2□ F	55	Yrs.	MODIFIES	Days	Tiodis		uly 6,	1950		ecticut
	land ow		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary a-f sh	ţo	Maryland Mont	gomery		German	town							1 ☐ Yes 2 🙀 No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	ntry?
	ath wi	ral	20716 Crystal					874					5.A.	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show ileal Exempter must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decede	es?	i			spanic Ori n, Mexicar	igin? (Spec n, Puerto P	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
920	urs af	by	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	X:		1□Yes :	2 [≹] No	Specify:			Sp	ecify: Whi	te
21215-0036	72 hours "natural",	Completed		ent's Education nest grade completed)		16a. Deced	kind of wor	rk done a	luring mos	t of workin	g	16b. Kind	of Business/Ir	ndustry
121	within ene. than "	mpi	Elementary/Secondary (0-12)		or 5+)		oo not us iver	e retired,)			A = 1 +	o Part	
d 2	filled Hygi ther ant, I		17. Father's Name (First, Middle	ə, Last)		1 DI	Ivei		18. Mothe	er's Name	(First, Middle,			.8
lan	Mental Mental arked o	To Be	Charles War	d					Ros	se]	Marie	Sch1	imak	
Maryland	and and ls m		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	g Address	(Street a	and Numbe	er or Rural	Route Numbe	r, City or To	wn, State, Zij	Code/20874
	1 and 2 Health tem 27		Carol A. Ward	- Wife	20h (207			1 Hil		rcle- A	•		ntown, Md.
Jore	0 0		20a. Method of Disposition 1 Burial 2 Tremation		ate	cemetery, cren	natory or o	ther place	.				ion - City or T	
Baltimore,	그 문원 등		4 □ Donation 5 □ Other 21. Signature of Fure-ral Service		Met	ropoli					The second second second second			Virginia
Ba	Depa Impo any ii		I trut &	I. Will	cam	20	5401_	Ridg	e Roa	ad, Da	P.A., amascus	, Mar	al Hom yland	20872
			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	st only one cause on eac	h line.									Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Ne	lave	he s	on 1	Ima	ع الله	ell	lun	g Can	nen	8 months
	Examiner			500 00 (01	as a consec	querice ory.								
	ש ≓	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
	ecute and I-trans	каш												
8760,	ate be executed hysician and the burial-transit			200.00 (6)	45 4 5011500	(001.00 01).							- 1	
9	ifficate by g physical as the b	Physician/Medical												
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pr	egnancy				23d	. Date of deliv	*
.O.	at the dea by the at tached fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnan 9□ Unknow			Other (sp						Month	Day Year
<u>α</u>	de ed		Part II. Other significant condi	tions contributing to deat	h but not res	sulting in the ur	nderlying c	ause give	n in Part I		23e. Did to	bacco use	contribute to t	he cause of death?
Vital Records,	quires n sign	ed by									1 X Y	es 2□N	io 3 🗆 Prol	bably 4 DUnknown
000	law requiras been si 2 should I	ompleted									24a. Was a		4b. Were auto	opsy findings available ompletion of cause of
l Re		Com									autops perfor	med2 2 No	death?	
/ita	Physician: this certificaral director, p	Be	25. Was case referred to medic examiner?	Hospital:				1000			(Check only or	ne)		
of	Phys r this ral dii	: To	1 Yes 2 No 27. Manner of Death	1 ∐Inp 28a. Date of I	niury	ER/Outpatien 28b. Time of			4 🗆 190	irsing Hom	e 5 eside		Other (Special	(y)
HO	Attending I r death. sctor: Alter by the funer	ation	1 Natural 5 ☐ Pend	/A A com the	Day Year)	Injury	М	8c. Injury Work 1 🔲 ۱	? (es 2 🔲					
Division		Certification:	3 Suicide 6 Coul	mined 286. Place of	Injury - At h	ome, farm, stre	eet, factory	, office		21	8f. Location (S. City or Town		umber or Run	al Route Number,
	spital or A ours after neral Directiled in by	Cert		building	, 616. (Opacii	· · · · · · · · · · · · · · · · · · ·					Ony 0/ 1011	o, orare)		
	Fund Bly	Medical	29a. Certifier Check only 2 Medica	ring Physician: To the be al Examiner: On the basi and manner	s of examina	owiedge, death ation and/or inv	occurred restigation,	at the tim in my op	e, date an inion, dea	id place, ar ith occurre	nd due to the c d at the time, d	ause(s) and late and pla	d manner as s ice, and due t	stated. o the cause(s)
	To the within 2 To the cor plet	2	29b. Signature and title of certif	ier				. License	_	, _	2	ed. Dare s	gnea (ivional,	Day, real)
)			welly	/				05	276	7		21:	3/200	0 (
	0		30. Name and ad rass of erso					lat	Dead	D	0 01 1 1 1	la M	. mr. 1	1 20052
:	Sta Registr		Harminder S. 31. Date filed (Month, Day, Yea FEB		ar'e Signs	ature	-		ı pri	ve, R	lockvill	ie, Ma	ıryıano	1 20852
	, ricgisti	ur			The state of the s		7	-						

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment rtificate			ınd Mei		giene 06	0493	3
, W.	Dhysiai	ã.	1. Decedent's Name (First, Middle, La	st)					2.	Date of Dea Month		3. Time o	f Death
	Physici /Medi		Gladys Eliz		ndsor	T				ebrua	7		0AM ^M
	Examir	ner	4a. Facility Name (If not institution, giv		77			Location of			4c. County of		
*		₹. ~.	Washington A 5. Social Security Number 6. S		HOSPICA (In yrs. last birthday			ma P		Date of Birtl	h 9	Birthplace (State Country)	
2	Funeral Director			1□M 2√F	59 Yrs.	Months	Days	Hours	Min.	(Month, Day	9,1946		
	P.		Usual Residence of Decedent		10.00 7						7,17.10		
	ehov	5	MD 10b. County Prince	Georges	10c. City, Town or L Chelten							10d. Inside C	2 □ No
	28a-f	ecto	10e. Street and Number			10f. Zip	Code				10g. Citizen of Wha	ot Country?	
	3a or		10007 Dakin	Ct.		101. 2.0		623			USA		
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Deced	ent of H	spanic Orig	in? (Specif	y Yes or No- an, etc.)	14. Race -	American Indian, White, etc.	
9	after or Its	Fu	1 Never Married 2X Married	1 Yes 2 XN	0	1 Yes 2			, r deito riio	A11, 6(0.)	Specify:	Black	
8	hours tural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dan	dent's Usua					16b. Kind of Busin		
15	in 72 n"n	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Giv	kind of wor DO NOT us	k done d	turina most	of working		100. Killa of Basil	essindustry	
212	d with giene.	om	Elementary/Secondary (0-12)	College (1-4or 5-		losiv	e O	pera	tor		Federa	l Gover	nment
	al Hyg	Bec	17. Father's Name (First, Middle, Last								Maiden Surname)		
<u>Xa</u>	ould b Ment arked aric e	2	Louis E. Cou								odland		
Mar	12 sho		19a. Informant's Name/Relationship (Joseph E. Wi		1	-					m, City or Town, Sta		
	1 and Health		20a. Method of Disposition	nusur	20b. Place of Disp	osition (Nam	ne of		Date		20c. Location - Cit	·	
JO.	ages int of t: If It		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		Resurr	matory or ot	her plac		2/10/	/06	Clinto		
Ħ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show many injury or other traumatic event, the Medical Exacult at must be retilled at DDGs.		21. Signature of Funeral Service Lice			2. Name and	d Addres	s of Facility	v			-	
B	Depariment of the policy of th		The state of			Adams	Fu	nera.	l Hor		A- 2060 uasco, l		co RI 8
意			23a. Part1. Enter the disease, or com shock, or head failure. List only	plications that caused	the death. Do not er	ter the mode	of dyin	g, such as o	cardiac or re			Approxima Interval Be	te
	Physician		Immediate Cause (Final disease or condition	Refr	actions	Car	di	n 90v	11 C	Sho	cv	Onset and	
	/Medical Examiner		Due to (or as a consequence of):										1-
	LXdiffiller	_	Sequentially list conditions,	b. Aord	10 Vall	le 1	rep	lace	men	t		da	15
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Crit	10 1 A	rtic	<1	enns	19			montl	1<
Ć,	execunand and iaf-tra	Exal	that initiated events resulting in death) Last	Due to (or as a	consequence of):	1			<u>, , , , , , , , , , , , , , , , , , , </u>				
Don of Vital Records, P.O. Box 68760, Berrilicate be executed U.S. Box 68760, Berrili. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	cate be executed by sicien and the burial-transit	Physician/Medical	d										
9	death certifica attending ph d for use as th	Med	IF FEMALE:					· · · · · · · · · · · · · · · · · · ·					
80	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death 3	⊒Ectopic pre					23d. Date of Month	f delivery Day	Year
_	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∏Pregnant at t 9∏Unknown	time of death 5	Other (spe	ecity)						
	that the de ned by the a detached f		Part II. Other significant conditions	contributing to death bu	t not resulting in the	ınderlying ca	ause give	en in Part I.		23e. Did to	bacco use contribu	te to the cause of	death?
rds	w requires that s been signed t should be det:	ed by	Thyrotox	100515						1 🗆 Y	es 2 1 No 3	Probably 4	Unknown
000	s bee	Completed	Preopera	five h	eart	fail	LLVE			24a. Was		e autopsy findings	available
R	ysician: The lav is certificate has director, page 2	mo:								autop perfor 1 Yes	rmed) dea	r to completion of th? Yes 2 \(\subseteq No	cause o
ita	slan: artifica ctor, I	BeC	25. Was case relerred to medical examiner?					26. Place	of Death (C	Check only o			
7	hysic this co	은	1 ☐ Yes 2 ☑ No	1 🗷 Inpatier							lence 6 Other	Specify)	
on C	ding Phys	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	M 28	Bc. Injury Work	/at <br Yes 2.∐N		I. Describe h	now injury occurred		
isi	Attendin death. ctor: A y the fu	ficat	2 Accident investigatio 3 Suicide 6 Could not b	99 Place of Inju	ry - At home, Jarm, s			163 2 1		. Location (S	Street and Number	or Rural Route Nur	nber.
Div	al or / after Dire d in b	Certification:	4 Homicide	building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,	,			City or Tow	vn, State)		
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of	l my knowledge, dea	h occurred a	at the tim	ne, date and	d place, and	due to the	cause(s) and mann	er as stated.	-)
	the H iin 24 the Fi	ledical	one)	and manner state	led.				n occurred				S)
	With To Con	Σ	29b. Signature and title of certifier) 0	117	29c.	~	number	_		29d. Date signed (A	-	
•			1 Monet	Mul	NUJ	D-1-11	1) =	3620	7		Februa	y 5,0	2006
(1.8		30. Name and address of person who Thomas Milita	•	ath (Item 23a) (Type 10 Carro		V.C	C+~	110	По	ma D1	ND 00	012
200	Sta	ite	31. Date lited (Month, Day, Year)	32. Resistra	r's Signature	TT W	ve.	ste	440,	Tacc	mma Park	, MD 20	912
0.0	Regist		FEB 0 7	32. Registra 2006	va St. ,	porte	j						

Physici /Medic Examir		1 - State Registrar Amend#29d.PerPhys.PGC 2-6-066 1. Decedent's Name (First, Middle, Last) Carl Lee Wheatley							· ·	2. Date of Month	D	ay Year	3. Time o	of Death	
		4a. Facility Name (If not instit				Y	4b. City	, Town, or	Location of De	Januar ath		c. County of Dea			
CAUIII		7419 Longl										Prince G		_	
Funeral Director		5. Social Security Number 220-52-0185 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthda) 57 Yrs.						New Carrollton Figure 1 (If Under 24 Hrs. Months Days Hours Min. 10-12-48					r) 9. Birthplece (State or Foreigr Country) Maryland		
MON		Usual Residence of Deceden 10a. State 10b. Con			ocation						10d. Inside C	City Limit			
in the control of the	ctor	MD Prin	ice G	eorge's	s N	New Carı	rrollton						1 ⊈Yes	s 2 🗌 No	
natural, or Items 23a or 28a-f show dical Expression make be notified at	Funeral Director	10e. Street and Number 7419 Longbr	n n a h	Desires								itizen of Whal Co	ountry?		
TS 23	era	11. Marital Status	ancn	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						U.S.	nican Indian.				
Examina	b	1 Never Married 2X 3 Widowed 4 Divor		1 🔀 Yes If Yes, Gir	1⊠Yes 2 \ No 12-5-00			lf Yes, specify Cuban, Mexican, Puèrio i 1 □ Yes 2 ⊠ No <i>Specify:</i>			Rican, etc.) Black, Wr				
Medical	letec	15. Dece (Specify only hi	dent's Edu ghest grad	ucation de completed)		16a. Dece (Give	dent's Usu kind of wo	ial Occupa	tion uring most of w	rorking	16b.	Kind of Business	/Industry		
25	Completed	Elementary/Secondary (0-12) College (1-4or 5+)							S. government						
tic event. I	To Be Co	17. Father's Name (First, Middle, Last) William H. Wheatley 18. Mother's Name (First, Middle, Maiden S Frances Chester								Sumame)					
item 27 Is marked other traumatic ev	F	19a. Informant's Name/Relati			Nife	19b. Mailii 7 4 1 1	ng Address 9 Lo:	s (Street a	nd Number or I anch [Pural Route Num	And Route Number, City or Town, State, Zip Code 784. New Carrollton, MD				
iry or oth		20a. Method of Disposition p☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe			State	Place of Dispo cometery, crei heltenh	natory or c	other place		7–06		ocation - City or eltenham			
any niury or oth		21. Signature of Funeral Serv	ice Licens			/ 22	. Name ar	nd Address	s of Facility	Bonnett E., WDC		Assoc.	Funera	1 Hm	
ician dical	E 01	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	or complist only of	a. Cardia	acn line.	ath. Do not ent							Approximal Interval Bei Onset and	tween	
niner	cal Examiner			Due to (or as a consequence of): Hyputusion te to (or as a consequence of):								415			
s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Understrying Cause (Disease or injury that initiated events resulting in death) Last Diabets Aulifus Due to (or as a consequence of): Due to (or as a consequence of):									Yrs,				
ed by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of deli Month		Year			
should be deta	by	Part II. Other significent cond	litions cor	ntributing to de	ath but not re	sulting in the ur	nderlying c	ause giver	in Part I.		tobacco		nbute to the cause of death? 3 Probably 4 Unknown		
page 2	e Completed	autopsy prior to performed? death?								prior to death?	topsy findings completion of c				
ector: After this cer by the funeral direct	To Be	examiner? 1 X Yes 2 No		26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (S)						6 MOther (Con-					
	Certification; T	27. Manner of Death 1 XNatural 5 Pen 2 Accident inve	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No							•					
			ld not be rmined						(Street ai	Street and Number or Rural Route Number, wn, State)					
completely filled in	edical	29a. Certifier 1 ★ Certification (Check only one)	ying Phys al Examir	sician: To the ner: On the ba and mann	sis of examin	iowledge, death ation and/or inv	occurred a estigation.	at the time , in my opii	, date and plac nion, death occ	e, and due to the	e cause(s) and manner as d place, and due	stated. to the cause(s	;)	
E .	Σ	29b. Signature and title of cort	fier					. License			29d. Da	te signed (Month			
- 8		30. Name and adjusts of person who completed cause of death (Item 23a) (Type, Print)							01	30 06 2/1/06					
To the complet		The state of the s	٠.					00)	628		+	30 / 0/2	2/1/00		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 29, 2006 **Physician** 2:40 a. M Williams Andre Damon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Prince George's 3107 Good Hope Avenue Temple Hills If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 27 Yrs Unknown Director Nov. 29, 1978 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits with the Maryland 10a State 10b Counts piene. or then "natural", or Itama 23a or 28a-f ahow The Modical Examinar must be notified at 1 XYes 2 No Funeral Director Temple Hills Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2513 Keating St. 20748 filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 7 No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Mantal Status 1 √ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Mover Tech. Private Industry 11 II Hygie traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be fil ment of Health and Mental H lant: If Itam 27 Is marked otf Sharon L. Costa Lonnie V. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Keating St., Temple, Md., 20748 Sharon L. Brown/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20 permit. Page Depertment of Important: If any injury or ance. Lincoln Mem.Cemetery 2/8/06 Suitland, MD. 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4111 Pa.Ave., Suitland, Md. Mary E. Cedar Hill Funeral Home 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nl-e Physician /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Attanding Physician: The law requires thet the deeth certificate be executed use es the burial-transit that initiated events physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No certificete 1X Yes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) At SCENE Hospital: ဥ 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) eral Diractor: After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 27. Manner of Death Finjury A M 1 Natural 5 Pending 1 Yes 2 No death. investigation 29/06 Subject shot 2 ☐ Accident 281 Location (Street and Number or Rural Route Number, City or Town, State) 3107 Good Here Ave Temple Hills MJ 6 Could not be 3 ☐ Suicide 4 X Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter Parkery To the Hospital within 24 hours e To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain a state.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 29, 2006 allen ma Baltimore, Maryland 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street COROL H tretwind 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 6 2006

			1 - For State Registrar	S	State of N	/larylan		artmen rtificate			and M	lental Hy	giene Reg. No		0493	
	Dhusisi		1. Decedent's Name (First, Mi	ddle, Last)		_						2. Date of De. Month	ath Day	v Year	3. Time of D	eath
	Physici /Medi		RUTH				Ţ	VEXLE!	R			FEBRUAR	RY 1	2006	2:40P	М
	Examir	er	4a. Facility Name (If not institu	tion, give stre	et and numbe	r)		4b. City,	Town, or	Location o	of Death		4c.	County of Deat		
			CASEY HOUSE	6. Sex	7.6	Nan (la ura	last birthday)	If Under		OCKVI		8. Date of Bin	h		OMERY hplace (State or I	To so inco
*	Funeral Director		5. Social Security Number 082-03-8028		2 √ F	88	Yrs.	Months	Days	Hours	Min.	OCT 25	y, Year)	Co	npiace (State of Puntry) NY	-oreign
			Usual Residence of Decedent									001 23	17.	1./	NI	
	rylan how		10a. State 10b. Cou	-		10c. Cit	ty, Town or Lo								10d. Inside City	
	Ba-f s	cto	MD M	ONTGOM	ERY			SIL	VER S	SPRIN	G				1 X Yes 2	
	with the	Director	10e. Street and Number	TOMAT	DDIVE :	H= 1.=		10f. Zip	Code	200	0.0		10g. Cit	izen of What Co	•	
	hours after death with the Maryland turs!, or Items 23a or 28a-f show at Examiner outs be notified at	ral	3701 INTERNAT		Was Deceder		6 12	Mac Dasse	last of Lie	209		ecity Yes or No		U.S.		
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ N		Armed Forces	s?	.5.	f Yes, spec	ify Cubar	, Mexican	n, Puerto	Rican, etc.)		Black, White		
936	hours at	b	3 XWidowed 4 □ Divor	36.55	If Yes, Give Year or Dates	_		1 🗆 Yes	2X No	Specity:				Specify: WH	HITE	
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2	within ene.	nple	Elementary/Secondary (0-1		College (1-4o	r 5+)	life.	DO NOT us	e retired)	,,,,,g		9				
2	Hygier Hygier other th		12 17. Father's Name (First, Midd	llo (act)			BOOKE	(EEPEI		10 Motho	e's Name	e (First, Middle,	Maidan	GIFT S	HOP	
Maryland 21215-0036	e d la b	Be	ISADORE TURKO									SILLICK	Maiueri	Sumame		
2	2 2 2 2	2	19a. Informant's Name/Relation		Print)		19b. Mailir	na Address					ar City o	r Town, State, 2	in Code)	
<u>8</u>	nd 2 sho lith and 27 is m		IRWIN M. WEXL					•				LLE, TN	. ,	7205	., ,	
ē,	s 1 and 2 of Health a item 27 is		20a. Method of Disposition				Place of Dispo cemetery, crer	sition (Nan	ne of			Date		ocation - City or	Town, State	
5	S = 50		1 🖾 Burial 2 □ Cremation 4 □ Dop atio n 5 □ Other		oval from Stat		NG DAV				2/05	/2006	FALI	S CHURC	H, VIRG	INIA
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Sen	ce Licensee			DA		SKY-G	OLDB:	ERG			HAPELS, E, MARYI		352
8760,	Physician /Medical Examiner parisist and par	dical Examiner	shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		METASTA Due to (or a Due to (or a	ATIC I	uence of):	ANCER							Interval Betwee	
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown Part II. Other significant cond		If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	il déath 3 🗆 leath 5 🗆	Ectopic pr Other (sp	ecify)	n in Part I.	,	23e. Did to		23d. Date of del Month	ivery Day Ye	
rds	w requires been sign should be	ed b				,						101	Yes 2	□No 3	obably 4 □Un	known
of Vital Records,	The law te has b age 2 sl	Completed										24a. Was autor perfo		prior to	topsy findings av completion of cau	allable ise of
ita	certifical rector, p	Be C	25. Was case referred to med examiner?							26. Place	of Deat	h (Check only o				
	ding Phys h. After this funeral di	ဥ	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Per	Hos iding istigation	pital: 1 ☐ Inpa 28a. Date of In (Month, D		ER/Outpatier 28b. Time of Injury		8c. Injury Work	4 🗆 190		me 5 Resident			enty) HOSPIC	CE
Division	tal or Attendi s after death. al Director: A ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Cou	ild not be emined	28e. Place of I building,	njury - At he etc. (Specif	ome, farm, str	eet, factory	, office			28f. Location (S City or Tox	Street an vn. State	nd Number or Ru	ıral Route Numbe	er,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier 1X Certi (Check only 2 Medione)	ying Physici al Examiner	an: To the bes On the basis and manners	of examina	owledge, death	occurred vestigation	at the time in my op	e, date and inion, deat	d place, th occur	and due to the red at the time,	cause(s) date and	and manner as diplace, and due	stated. to the cause(s)	
	To the Comp	ž	29b. Signature and title of cert	ifier	•			290	. License	number			29d. Da	te signed (Monta	h, Day, Year)	
)	10		1/40	~~		.77				D3563	35		feb	2, 2006		
	V		30. Name and address of pers													
	days.		DR. JOSEPH KA			JNCAST strar's Signa				KVIL	LE,	MD 208	55			
	Sta Registi			3 200	6		S A	ede								

State of Maryland / Department of Health and Mental Hygiene 04935 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 1, 2006 **Physician** Margaret E. Williston 3:40P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 7019 Fitzpatrick Drive Laure1 8. Date of Birth (Month, Day, Year) Nov. 21, 1948 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 215-54-5254 57 Washington, DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Laurel 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7019 Fitzpatrick Drive 20707 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene.

Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Computer Science Corp. permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Impordent. If item 27 Is marked other til
any injury or other treumatic event, In
once. and Mental Hygier Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylvia Skinner John M. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Williston, Sr. -husband 7019 Fitzpatrick Drive Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Ocremation 3 ☐ Removal from State Metropolitan Crematory 2/4/2006 Alexandria, Virginia ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee lonald V. Borgwardt Funeral Home, PA Danald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complier ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 day Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Squamous Cancer of Hypopharynx 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed use as the burial-tran attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified ٥ February 2, 2006 12 D34714 mpleted cause of death (Item 23a) (Type, Print) en, M.D. 22 S. Greene Street, N9E17 Baltimore, Maryland Name and a fress of person who completed Kevin Joseph Cullen, egistrar's Signature State FEB 03 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene 🛭 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Dona1d Richard Walters JANUARY 27 2006 0723 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 12/01/1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F 81 Director 196-14-9450 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Wadigal Examinat must be notified at once. 1 XYes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Eastern Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ŬYes 2□No 1943 -IYes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 □ Widowed 4 □ Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Brakeman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell Palmer Walters Cora Belle Trail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jason Walters / grandson 114 Glenfield Court, West Lawn, PA 19609 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory |01/28/2006 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2. autopsy performed 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Tyes 2 → No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the days (s) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/1UA JANUARY 27 2006 D54411 mpleted cause of death (Item 23a) (Type, Fint)
5 500 MEMORIAL AVENUE SUITE 105 CUMBERLAND, MD DR. BEVERLY CALKINS nRs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State IAN 3 0 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cel</i>	artment of rtificate of	Health and Death		giene () () ()	04937
	5.2		1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day Ye	3. Time of Death
	Physici /Medio		Delores	<u>l.</u>	V	/olfgan	9		02	13 200	1 1 10 1 10 10 10 10 10
	Examir	er	4a. Facility Name (If not institution					or Location of Dea		4c. County of E	
		micke	5ACRED HEA	6. Sex	7. Age (In yrs.		If Under 1 Yea	era land			GCNU Birthplace (State or Foreign
· .	Funeral Director		175-26-5944	1 □ M 2 🙀 F	75	Yrs.	Months Days			1930	County!
3.7	p		Usual Residence of Decedent								
	a-f show	ctor	PA 10a. State Schu	ıylkill	10c. Cr	y, Town or Lo Ashla					10d. Inside City Limits 1 ☐ Yes ※☐ No
	vith the	Funeral Director	10e. Street and Number				10f. Zip Code	17001		10g. Citizen of Wha	
	eath v	erai	603 High Road 11. Marital Status	12 Was Do	cedent Ever in U	C 12.1	Mac Docadon of	17921	Consider Van or No	USA	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any Injury or other traumatic avent, the Medical Examinating the Inditited at ance.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	orces? 2 No live No	1	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer Descrity:	to Rican, etc.)	Black, V	Vhite, etc.
Ö	2 hou	Completed by	15. Decedent	's Education		16a. Dece	dent's Usual Occi	pation		16b. Kind of Busin	
215	thin 7	npie	(Specify only highes Elementary/Secondary (0-12)	T				e during most of wa ed)			
2	ygien ygien rt. Ing	Con	12	1	(1-4or 5+) 2	homen	naker			own home	<u> </u>
Maryland 21215-0036	should be fill and Mental H marked oth umatic sven	To Be	17. Father's Name (First, Middle, I	Last)				18. Mother's Na Nellie		Maiden Sumame)	
	and 2 sho ealth and 1 n 27 le ma		19a. Informant's Name/Relationsh Leonard Wolfga		usband	19b. Mailir 603	ng Address <i>(Stree</i> High Roa	at and Number or R	ural Route Numbe Ashla	er, City or Town, Sta. nd	PA 17921
altimore,	Pages 1 and of Height of H		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		Charles	semetery, crer	sition (Name of matory or other planet nel Cemete	ace)	Date 2/18/2006	20c. Location - City Mount Ca	
Baltir	permit. Page Department Important: It any Injury or once.		21. Signature of Funeral Service I	**	HIAN	. 22	. Name and Add	ess of FacilitySca	arpelli F		ome, PA for
	7		23a. Part . Enter the disease, or shock, of heart failure. List	complications that	caused the deat						Approximate
*	Physician		shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	Ke	ooogo o. o,		o or recognitiony ar		Interval Between Onset and Death
*	/Medical Examiner		rosuming in doutin	Due to	(or as a conseq	uence of):					
1	pi ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to	(ur as a conseq	uence of).					
o,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):					
	cate be physicia the bu	dical		d							
Box 6	death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d. Date of	deliverv
Ö.	at the death certific by the attending parached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		birth 2∏Feta nant at time of d nown		Ectopic pregnant Other (specify)		, , , , , , , , , , , , , , , , , , , ,	Month	Day Year
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rds	w requires been sign should be	ed by	Hypertens	ien					1 □ Y	'es 2. 10 3 □	Probably 4 Unknown
Vital Records,	awre	Completed	/ /						24a. Was		autopsy findings available
ř	: The law cete hes l page 2 s	E O								rmed?deat	to completion of cause of h? Yes 2 No
Ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?					26. Place of De	ath (Check only o		
<u>></u>	Phyeid this contract	P,	1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatien	1 3LI DOA		dome 5 Resid	lence 6 Other (S	Specify)
Ĕ	ding P h. After t funera	in o	27. Manner of Death 1 □Natural 5 □ Pending		of Injury oth, Day Year)	28b. Time of Injury		ork?	28d. Describe h	low injury occurred	
Division of	tend death stor:	cat	2 Accident investig 3 Suicide 6 Could n	ot be	o of Injugy . At h	amo farm et-	M 1 []Yes 2 □No	29f Location /6	Street and Number	r Rural Route Number.
2	al or Attend after death Director: v	Certification;	4 Homicide determi	ned 200. Place	ling, etc. (Specif	y)	set, factory, office		City or Tow		r Aurai Aobie Wulliber,
	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certifical completely filled in by the funeral director; p		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	wledge, death	occurred at the	me, date and place	e, and due to the o	cause(s) and manne	r as stated.
	in 24 he Fu	edicai	one) 2 Medical t	Xaminer: Un the	nner stated.	tion and/or inv	estigation, in my	opinion, death occ	urred at the time, o	date and place, and	due to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier	1	n n		29c. Licer	se number		29d. Date signed (M	lonth, Day, Year)
1			Muninger		11111.		D S	6207		Festivery	13,2006
	4		30. Name and address person v		se of death (Item	23a) (Type,	Print)	0	0 1	1 / 1	13,200 6 Varyland 21502
200	0		31. Date filed (Month, Day, Year)	noun	Registrar's Signa	40C	Selon	Drive	Lumbe	rland, M	aryland 21507
	Sta Registr	_	FFB 1 7 2	006	Ser A	Asset				•	1

WAYNE D. WOLFORD 06-01007 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 4a, b, c per meo g852 2-17-06 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay Pea Pebruary 8, 2006 **Physician** WAYNE DOUGLAS WOLFORD 5:18 p. M /Medical 4c. County of Death Allegany 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Memorial Hospital Fort Ashby Cumberland Mineral $_{
m WVA}$ If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 234-62-4582 63 Director JULY 1,1942 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itema 23a or 28a-f ehov other trsumatic event, Ita Medical Examinar must be notified at 1 ☐ Yes 2 X No WV Director MINERAL FORT ASHBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if I tem 27 is marked other than "--- ery injury or other traument. 26719 BAKER ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: NO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 RUG ROLLER RENTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES WOLFORD WAYNE MILDRED ELLEN BLUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS MARIE WOLFORD / WIFE P.O. BOX 64, FORT ASHBY, WV 26719 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State FORT ASHBY CEMETERY 02/13/2006 FORT ASHBY, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, INC.
P.O. BOX 1260, FORT ASHBY, WV 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 26719 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Contact gunshot would to chest Due to (or as a consequence ot): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No this certificete 2 🗆 No 1 Yes 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2X ER/Outpatient 3 DOA 1 XYes 2 □ No Certification; To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Affer Injury 1 Natural 5 Pending s effer de. •••i Director: Alte shot self 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) Bux 64, Fort Ashoy, WV 4:17 PM investigation Feb 8,2006 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Pr Suicide filled in by 4 Homicide home To the Hospital within 24 hours e To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME February 9, 2006 Toroba Baltimore, Maryland 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street M.D. Tasha Z Greenberg

State Registrar

DHMH 17 Rev 1/2001

Box 68760

31. Date filed (Month, Day, Year) 32. F

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\$1	Physic	ian	Decedent's Name (First, Midd							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi	cal	4a Facilia None (46 - a to start)	MILSIE Y						FEB	2 2006	5	3:40 A ^M
	Exami	ner	4a. Facility Name (If not institution NATIONAL NAVAL				4b. City, Town,	or Location of THESDA			4c. Coi	unty of Death	
39	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year			8. Date of Bin	th.	MONTG	
	Director	~	555-38-0709	1 □ M 23C F	83	Yrs.	Months Days	Hours	Min.	Feb 27,	1922	A ₁₇	place (State or Foreign intry) Stralia
	pu *		Usual Residence of Decedent 10a. State 10b. County	,	10- 6	21. 27.							
	the Marylan 28a-f show notified at	ō				City, Town or Lo							10d. Inside City Limits
	28a-1	Director	10e. Street and Number	nce George	e · s		Lani	nam			10- 011	1110	1 ☑ Yes 2 ☐ No
	3a or	0	9117 7th Str	eet				20706				of What Co. ustral	
	death	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of f f Yes, specify Cub		gin? (Sp	ecify Yes or No		Race - Ameri	
21215-0036	d within 72 hours after death with the Maryland jiene. Ir then "natural", or Items 23a or 28a-f show the Mwilcel Exerting must be notified at	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	2 No ve		f Yes, specify Cub 1 □ Yes 2 🕱 No			Rican, etc.)		Black, White	
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Baltimore,	ges 1 al t of Hea if Item or othe		20a. Method of Disposition		206.	Place of Dispo	sition (Name of natory or other pla	1		Date		on - City or To	own, State
E	Pages nent of ant: If It ary or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			-	Nationa	· 1	/8/2	006	Arlin	gton,	777
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W			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of only one cause on e	aused the dea ach line.	th. Do not ente	er the mode of dyi	ng, such as	cardiac c	or respiratory ar	rest,		Approximate Interval Between
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8760,	cate be executed physician and the burial-transit	dical		d.									
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.O. Box	e death certifii he ettending p ied for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live b	inth 2 ☐ Feta ant at time of o	al death 3 □	Ectopic pregnancy Other (specify)	/				Date of delive Month	ory Day Year
Ρ.	that the de ned by the e detached f	Phy	9 Unknown Part II. Other significant condition										
Division of Vital Records,	The law requires that the ste hes been signed by th page 2 should be detache	ted by	Tarris Strong Significant Condition		aur but not res	sulling in the un	deriying cause giv	en in Part I.					ne cause of death? sably 4 XIUnknown
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ᄪ										1 Yes	med? 2007 No	death?	2 □ No
Ħ	Physician: this certific ral director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 25 No	Hospital:		1	3□ DOA Oth			(Check only or			
ō	g Physical dispersal di	7: 70	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o	of Injury	ER/Outpatient 28b. Time of	3□ DOA 28c. Injur	4 🗆 1401		ne 5 Reside			/)
<u>.</u>	Attending or death. ector: After by the fune	atio	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	g (Mont	h, Day Year)	Injury	Wor	k? Yes 2 □ N			on injury coo	31100	
<u>Vis</u>	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	of Injury - At h	ome, farm, stre	et, factory, office		2	28f. Location (St	reet and Nur	nber or Rura	l Route Number,
ā	itel or irs afte rel Diri	Cer		- Duildii	.g, 010. (<i>Opacii</i>	·y)				City or Towi	i, State)		
	To the Hospitel or Attending Ph Within 24 hours after death. To the Funerel Director: Alter th completely filled in by the funeral	Medical	29a. Certifier Check only one) Certifyin 2 Medical	g Physician: To the Exeminer: On the ba	sis of examina	owledge, death ation and/or invi	occurred at the tirestigation, in my o	ne, date and pinion, death	place, a	and due to the ca	ause(s) and r	manner as st	ated. the cause(s)
	To the Within 2 To the complet	Med	29b. Signature and title of certifier	and main	er stated.		29c. Licens				9d. Date sign		
	->-0		Jan Down	son MD				415A	(TN)				
0	(6)		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type, F				AVAL ME	TEL 人		
	6			SOUR LCD		USN				D 20889		ODM TE	
	Sta		31. Date filed (Month, Day, Year)	31. Date filed (Month, Day, Year) 22. Registrar's Signature									
*	Registr	ar	FEB 0 3 21	JUTO ALL	ملا من	Ann							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	Physici /Medio Examin	a ca ie
DERSON, JULIUS ALBERT	Funeral Director	
NAME KNOWN TO PHYSICIAN: ANDERSON, JULIUS ALBERT Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-f show any injury or other traumatic event, the Medical Examination and Examination of Once.	To Do October

Physician /Medical **Examiner** To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		Ce	rtificate of		Rea	2006	04940
п	1. Decedent's Name (First, Middle, Las	()		-		2. Date of Death		3. Time of Death
an cal	Julius A. Anders 4a. Facility Name (If not institution, give			4h Cihi Town o	Localion of Death	FEBRUARY	15, 2006	
ier	VA MARYLAND HEALTH						·	un
	5. Social Security Number 6. Se		rs. last birthday		POINT If Under 24 Hrs.	8. Date of Birth	CECIL	thplace (State or Foreign
	213-12-3036 Usuel Residence of Decedent	M 2□F 85	Yrs.	Monihs Days	Hours Min.	May 18,	ear) C	cyland
	10a. State 10b. County	10c.	City, Town or L	ocalion				10d. Inside City Limits
to	MD Cecil		Perryv	7 i 11e				1 ☐ Yes 2 ☐ No
rec	10e. Street and Number			10f. Zip Code		10g	. Cilizen of What C	
rai D	100 Greenway #40				21903		USA	,
nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spi in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Completed by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14	1-45	1 ☐ Yes 2 ☑ No	Specify:		Specify: w]	
letec	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece (Give	dent's Usual Occup	during most of work	ing 16	b. Kind of Business	/Industry unk
ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 2		DO NOT use retired lithograp	,			
Be C	17. Father's Name (First, Middle, Last)			TTEHOGRAP		e (First, Middle, Mai	iden Sumame)	
To B	Julius Albert A	nderson Sr			Matilda	Estelle	MaVannia	
-	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street a	and Number or Rura	al Route Number C	ity or Town State	Zin Code)
	Marcelle J. And		4	Greenway				
U. 3	20a. Method of Disposition		. Place of Dispo	sition (Name of			MD 2190; Location - City or	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 14 ☑ Donation 5 ☐ Other (Specify)) /		matory or other plac				
	21. Signature of Funeral Service Licens Rona Ld. S	Wade, Direct		2. Name and Addres tate Anato altimore.	omy Board	655 W. B	altimore	Street
	23a. Pa 11. Enter the di ease, or composh ck, or heart failure. List only o	lic tions that caused the de						Approximate Interval Between
	Immediate Cause (Final disease or condition	ACUTE MYOC	ARDIAL	INFARCTIO	N			Onset and Death UNKNOWN
	resulting in death)	Due to (or as a cons						Ontaionit
	Sequentially list conditions,	b						
ine	if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
кап	that initiated events resulting in death) Last	C. Due to /22 22 2						
Medicai Examiner		Due to (or as a cons	equence on:					
dic		d						
	IF FEMALE:	23c. If yes, outcome of preg	nancy					
Slan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del	ivery Day Year
ysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	1 002(1) 5[J Other (specify)	-			
/Ph	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderiving cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Completed by Physician/		,	3	,,,		1 ☐ Yes		obably 4 XUnknown
ete						-		, 41
ш						24a. Was an autopsy	prior to	topsy findings available completion of cause of
						performed	? death? No 1 Yes	2□ No
Be	25. Was case referred to medical examiner?	Janital.			26. Place of Death			
2	1 185 2 X 140	T-1	☐ ER/Outpatien	t 3 DOA Othe	r: 4 🕅 Nursing Hor	ne 5 Residence	6 □Other (Spe	cify)
o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how it		
cat	2 Accident investigation 3 Suicide 6 Could not be				es 2 No			
ill i	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stro cify)	eet, factory, office	2	28f. Location (Street City or Town, St	t and Number or Au tate)	ral Route Number,
ပ္								
Medical Certification:	29a. Certifier (Check only one) 1 ★ Certifying Physical Exemition (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	and due to the cause ad at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
Σ	29b. Signature and title of certifier	1	-1/2	29c. License	number	29d.	Date signed (Monti	n, Day, Year)
	Mamas	A 12160	UM) 11	M2000	i	N N	115/06	
	30. Name and address of person who co	empleted cause of death (It	em 23a) (Type	U D42800 Print)	<u> </u>		1,0100	
	THOMAS BIONDO, M.I				VCTPEM DE	ייידים עססי	חנר מוא מ	02
e	31. Date filed (Month, Day, Year)	32. agistrar's Sign	uature	TH CAKE S	TOTEM PE	TKKI POIN.	r v MD 518	02
ar	FEB 2 1 20	106	H A	200				
4		The state of the s	A.F.					

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 02/14/2006 **Physician** 6:16 AM Clarence Edgar Akers /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel **Annapolis** Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 11/02/ 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 1925 KY Director 231-26-4903 80 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentel Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinations that he notified at 10c. City, Town or Location 10d. Inside City Limits 10a, Stete 10b. County 1 ☐ Yes 2 No **Funeral Director** Anne Arundel Pasadena 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21122 U.S.A. 162 Kenwood Road 12. Was Decedent Ever in U,S.
Armed Forces?
12 Yes 2 No 194
HYes, Give
Year or Detes: 194 13. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1944 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Be Completed by Specify: White 1945 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) William James Akers Stella Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 162 Kenwood Road, Pasadena, MD 21122 Brenda Jann / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State injury or Depertment important: If any injury or 2/17/6 Glen Burnie, MD 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Mem Pk 22. Name and Address of Fecility G.J.Gonce Funeral Home, 21. Signature of Fune al Service Licenses 169 Riviera Drive, Pasadena, MD 21122 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditione contributing to death but not resulting in the underlying ceuse given in Part I. funeral director, page 2 should be deteched 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 □ Yes 2 □ No T Yes certificete 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Medical Certification: To 1 Depatient 3 DOA 4 ☐ Nursing Home 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth or Attending 5 Pending investigation Injury Naturel 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) completely filled in by To the Hospital of within 24 hours of To the Funeral D 29a. Certifier The first of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				State of I							ental Hyg		o o c	01010
			1 - For State Registrar				rtificate					eg. No.	000	04942
	Dh(-)		1. Decedent's Name (First, Middle, I	_ast)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic			cita L.		al					Februa	ry 17	7, 200	
	Examin	er	4a. Facility Name (If not institution, g				4b. City, To						ounty of Deal	
			Genesis Knolly 5. Social Security Number 6		Age (In yrs. I	ast birthday)			rsvil If Under 2		8. Date of Birth		Anne A	
	Funeral Director		530-10-4325	1 □ M 2 🔀 F	8		Months [Days	Hours	Min.	8. Date of Birth (Month, Day, JUL 8,	1924	Mor	thplace (State or Foreign ountry) ntana
	P		Usual Residence of Decedent 10a. State 10b. County		100 Cib	, Town or Lo								10d. Inside City Limits
	shov	ō		1 1	Toc. City	, rown or Lo								1 ☐ Yes 2 XNo
	the N	Director	Maryland Anne A	rundel			10f. Zip C		ersv	ıııe	1	0g. Citizer	n of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show	I D	899 Cecil Aven	ue				21	1108				USA	
	ems 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Deceder	nt of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			erican Indian,
20	hours after tural', or ite	by Fu	1 Never Married 2 Married	1 XYes 2	□ No		1 ☐ Yes 2		Specify:			Sp		hite
2-003p	be filed within 72 hours after death with the Marylan ital Hygiene. 3d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show avent, the Marked Examiner of the mylified at		3 ☐ Widowed 4 ☑ Divorced 15. Decedent's		s: 1944 -	16a, Dece	dent's Usual (Оссира	tion			16b. Kind	of Business	
<u>y</u>	within 72 ene. than "nai	Completed	(Specify only highest s Elementary/Secondary (0-12)	grade completed) College (1-4)	or 5+)	(Give	kind of work DO NOT use	done di	uring most	of worki	ng			•
7 7	d with giene er tha	Com	Elementary/Secondary (0-12)	5+	01 3+7	F	ashion							Store
land	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	st)							(First, Middle, f	<i>Maiden S</i> u	mame)	
>	should nd Men marke imatic	2	George G. Lant 19a. Informant's Name/Relationship			10h Mailir	na Address (Stroot 2			Hudson	City or T	own State	Zin Code)
Z Z	S & 20 E		Craig I. Amaral				Locus	•			wnsville			
<u>5</u>			20a. Method of Disposition			lace of Dispo	sition (Name	of					tion - City or	
Ë	Pages ment of ant: If it ury or o		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from Sta cify)	ate	•	emator		1	2/1	8/06	Bal	timor	e. MD
Baitimore,	permit. Par Departmen Important: any injury once.		21. Signature of Funeral Service Lic	ensee			2. Name and							f MD, Inc.
D	2011		Edward A G	regorchik			299 F	rede	erick	Roa	d Balt	imore		21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each	sed the death h line.	Do not ent	er the mode	of dying	such as	cardiac c	or respiratory arre	est,	1-	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		as a consequ		LAZ	ACC	400	INI	Dovy	(NA	מין	1 year.
	Examiner			Due to (or	as a consequ	derice or).								
L	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):								
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequ	ienco of):								
/60,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cal E	1	Due to (or	as a consequ	ierice orj.								
28	ficate physics the			d										
XOD	anding use a	m/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna		Ectopic pred	202001				230	d. Date of de	*
	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of de		Other (spec						Month	Day Year
J Ö	d by the	Phy	9 Unknown Part II. Other significant conditions			ulting in the u	nderlying cau	ISO CIVO	n in Part I		23e Did tot	acco use	contribute to	o the cause of death?
S S	og Dec	by	Part II. Other significant conditions	s contributing to deat	ii but not rest	nung m me u	riderlying cau	ise give	n in Faiti.			s 2 🗆 N		robably 4 KUnknown
Records,	w require been si should I	Completed						_			24a. Was a	n 2	24b. Were at	utopsy findings available
	The law	dmo									autops perform	v	prior to death?	completion of cause of
Vital		o ·	25. Was case referred to medical						26. Place	of Death	1 Yes 2		10.163	20140
OT <	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2		nt 3□ DOA		40 Nu		me 5 ☐ Reside			cify)
	ttending Phys death. stor: After this of the funeral dir	on:	27. Manner of Death 1 Natural 5 □ Pending		njury Day Year)	28b. Time o Injury	f 280	c. Injury Work	at ? ∕es 2⊡I		28d. Describe ho	w injury o	ccurred	
Division		licat	2 Accident investigat 3 Suicide 6 Could not	t be	Injury - At ho	me, farm, str			65 2 🗀 1		28f. Location (St	reet and N	Jumber or A	ural Route Number,
2	after after i Dire d in by	Certification:	4 Homicide determine	building.	, etc. (Specify	1)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or Towr	, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Salc	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the be	est of my know	wledge, deat	h occurred at	the time	e, date an	d place,	and due to the ca	ause(s) an	id manner as	s stated.
	the Ho iin 24 the Fu	ledical	one)	and manner	notated.		-							
	To the vithin To the comple	Σ	29b. Signature and title of certifier	1001.	0		290.	License	2// >	/	2	So. Date s	igned (Mont	I / n n = ml
h	0		30. Name and address of person wh	o completed cours	of death /lea-	23a) /Tues	Print\	()	2113	6	F	CIJE	MIKH	11,6006
X	1		13 Li Au C.	NALLALC	U WW	900	5 1/1	16	RIDE	5 6	21), BA	ulm	occs, 1	(M) 21236
	Sta	te	31. Date filed (Month, Day, Year) FEB 2 1	2006 32 Reg	istrar's Signa	re					1 :-			
	Registr	ar	LFR % T	1000	Was of	4								

			1 - For State Registrar	State of Maryla		artment of H			2016	01.91.3
			Registrar 1. Decedent's Name (First, Middle, Last)		- 06	illicate of	Death	2. Date of Dea	Reg. No. OOO	3. Time of Death
	Physici		ALICE	T	AL	EXANL	ER	Febru	Day Year	6 745 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	,		or Location of Death		4c. County of Dea	
			510 MT. Holley	Street			ure		NA	
	Funeral		5. Social Security Number 6. Sex	M 2⊠F 7. Age (In yr.	s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. Bi	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent	/	الله الله			JAN. OI	1713 V	RGINIA
	yland yland		10a. State 10b. County	10c. (City, Town or L	ocation	<u>``</u>			10d. Inside City Limits
	a-fat	ctor	MARYLAND NI	A		GA.	LTIMO	RE C	171/	1 XYes 2 No
	or 28	Jire	10e. St/eet and Number			10f. Zip Code	1		10g. Cirizen of What C	ountry?
	ath w	Funeral Director	310 MT.	40LLEY.	57	1	2122	9	U5	A,
	ter de	une	11. Marital Status 1 Never Married 2 Married	 Was Decedent/Ever in Armed Forces? 1 ☐ Yes 2 ☑ No 	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	- 14. Race - Am Black, Whi	
36	irs aft		3 ★ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	IACK
9	filed within 72 hours after death with the Maryland Hygiene. After than "natural", or items 23a or 28a-f show ant, the Medical Evant are must be collified at	Completed by	15. Decedent's Educ (Specify only highest grade	ation	16a. Deca	dent's Usual Occup	pation during most of wor	rkina	16b. Kind of Business	s/Industry
215	thin 7 e. en "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		811	1
7	filed with Hygiene. other than		1 FAGRADE		<i>F</i>	OME	MAKER		OWN FI	OME
Maryland 21215-0036	d ta b	Be	17. Father's Name (First, Middle, Last)	TEE	FERS		18. Mother's Nan	ne (First, Middle,		OLDIN
ž	should tind Ment	은	19a, Informant's Name/Relationship (Type			na Address /Street	and Number or Ru	/† Iral Route Numbe	or, City or Town, State,	
Ma	and 2 sho ealth and n 27 is m		LOUISE WINDER	1-	1.51	OHT	HOLLEV:	ST. 13/	TITO HI	0.2/229
ē,	s 1 and 2 f Health Itam 27 othar tra		20a. Method of Disposition	20b.	. Place of Dispo	osition (Name of matory or other pla	cal	Date /	20c. Location - City o	Town, State
E	Page lent o nt: If ry or		YSBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	imoval from State	RBUT	1	STERVOZ-	20-06	ARBUTUS	S. MARVIANO
Baltimore,	permit. Pages: Department of H Important: If Its any injury or ot		21. Signature of Funeral Service License	10. 19		2. Name and Addre			HON AVENUE	2/2/7
<u> </u>	89 = 88		a retrick N	· Willia	m J	05eph H.	Brown Jr	Funera	1 Home Ba	Himore MO.
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the de e cause on each line.	ath. Do not en	ter the mode of dyi	ng, such as cárdiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Denu	rat	-10M				iweek
	/Medical Examiner		resulting in death)	Due to (or as a bons	equence of):	4				many ware
b		e.	Sequentially list conditions, b.	Due to or as a cons	ouence of:	4				many gears
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	exec an and rial-tra		resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physician and the burial-transit	dicai	d.							
9	death certifica attending ph d for use as t	Med	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	Sc. If yes, outcome of preg	tal death 3	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
0	that the death ed by the atte detached for	Physician/Me	1 ☐ Yes 2 ██♥o 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	rdeath 5L	Other (specify) _				
<u>α</u>	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	/ Ph	Part JI. Dther significant conditions con	ributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ds	w requires been sign should be	d b	Malnuthtie	20 du	pphae	na 2º	1	1 🗆 Y	es 2.0 No 3 □ P	robably 4 Unknown
CO	s been s shouk	olete		0	,	demen	itia	24a. Was		utopsy findings available completion of cause of
Re	The la	Completed by							med2 death?	
Vital Records,		Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o		
	2 .00	2	1 □ Yes 2. No		☐ ER/Outpatie	II 3LI DOA			ience 6 □Other (Spe	ecify)
Ē	ding P n. After t funera	iuol:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ☐ No	28d. Describe h	low injury occurred	
isio	Attanding or death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm st		Tes 2 140	28f. Location /5	Street and Number or F	Tural Route Number.
Division of	after Direct In by	Certification:	4 Homicide determined	building, etc. (Spec	cify)	oot, lactory, office		City or Tox		
	To the Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral			icien: To the best of my k						
	n 24 h	edical	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	opinion, death occu			
	To t Vithi To tl	¥	29b. Signature and title of certifier	0	1. 0	29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
•	101		Teslees &Co	mom	M.L	. 100	15284	/	Od 1161	2006
4			30. Name and address of person who cor	mpleted cause of deat It	em 23a) (Type,	Print)	+ Rot	Time nin	a MD-	1201
1	Cla		31. Date filed (Month, Day, Year)	22. Registrar's Sig	nature 🖋) raca?)1, Lecl	UMOV	c, INd	400
	Sta Registr		FFB 2 1 2006	Same As	A STORA	86.00				

		•	For State Registrar	State of Maryland / De	partment of Fertificate of			ene 006	04944
			1. Decedent's Name (First, Middle, Las	(1)			2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Grover Alex	xander			Februare	19 200	6 6° PM
}	Examin	_	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death	0	4c. County of Dea	th
			522 NEW PITTSBU	JRG AVENUE		STATION		BALTI	
	Funeral		5. Social Security Number 6. Security Number	G14 00 5	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	/ear) ∣ C	thplace (State or Foreign
	Director		Usual Residence of Decedent	KIM 2UF 82 Yrs			12-25-1	923	20
	and		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Mary! f sho	ŏ	MD BALTIMOR	RE TURNER	STATION				1 🛱 Yes 2 🗆 No
	28a	Director	10e. Street and Number		10f. Zip Code		109	g. Citizen of What C	ountry?
	3a or		522 NEW PITTSBUR	RG AVENUE	21	1222		USA	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified a	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
9	or the	F	1 Never Married 2 Married	1 □Yes 2 ▼No	1 ☐ Yes 2 ☐ No	Specify:	Tribari, Oto.,		LACK
<u> </u>	ural',	d by	3 AWidowed 4 ☐ Divorced	Year or Dates:					
7	nati	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (G	icedent's Usual Occup ive kind of work done e. DO NOT use retire	during most of work		6b. Kind of Business	vindustry
2	within	ш	Elementary/Secondary (0-12)	College (1.4or 5+)	E FITTER	u)		STEEL	
2	filed wil Hygien other th		17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
	Mental Merked o	o Be	DAVID ALEXANDER			LOLA	ALEXA	NDER	
<u> </u>	2 OFF	ပ	19a. Informant's Name/Relationship (7	Type, Print) 19b. M.	ailing Address (Street	and Number or Run	al Route Number, o	City or Town, State,	Zip Code)
	と言なる		DOROTHY CLAPP-WOO	DARD/DAUGHTER 861	8 DELEGGE	RD., BALT	IMORE, M	D 21237	
e e	of Health of Health fitem 27 r other tra		20a. Method of Disposition	cemetery (sposition (Name of crematory or other plan	ce)		Oc. Location - City or	
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Specify	Hemoval from State ARRITTI	S MÉM. PAF	RK 2/23/	/2006 B	ALTIMORE,	MD 21227
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licen	see A					NS F.H., INC
			THE MED ON	plications that caused the death. Do not				RE, MD 21	∠ I / Approximate
			Shock, or heart failure. List only	one cause on each line.	1	1		21,	Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metastatic	Colon	Canu	er		
9	Examiner		1	Due to (or as a consequence of):					
	V	-a	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):					
	uted 1 ansit	Examiner	Cause (Disease or injury that initiated events						6
ó	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):					
8760	ate be ex hysician the buria	dicai		. d					
9		Med	IF FEMALE:						-
Вох	death certifica e attending ph id for use as t	an/I	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnanc	у		23d. Date of de Month	Day Year
	0 0 2	Physician/Me	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify) _				
<u>a</u> .	res that the de signed by the a be detached f			ontributing to death but not resulting in th	e underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Division of Vital Records,	The law requires that the tee has been signed by the bage 2 should be detache	d by	1 410				1 ☐ Yes	2 □ No 3 □ P	robably 4 Qunknown
So	w requir been si should	Completed					24a. Was an	24b. Were a	utopsy findings available
Re	ysician: The lav is certificate has director, page 2	du					autopsy perform	prior to death?	completion of cause of
ā		e C	25. Was case referred to medical			26 Place of Deat	1 ☐ Yes 2) h Check on one		s 2□No
>	ysicia is cert direct	0 8	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3□ DOA Ot	her		nce 6 Other (Sp.	ecify)
Ö	Attending Physician: r death. ector: After this certific: by the funeral director,	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim		ry at	28d. Describe how	v injury occurred	
0	ath. or: Ath	atio	1 Kanatural 5 ☐ Pending investigation		*	Yes 2□No			
N N	l or Atten after deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in I	Ce	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowledge, d	eath occurred at the ti	me date and place	and due to the car	ise(s) and manner a	s stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medicel Exen	single O the trade of submissables and/s	a dance as a season of the control of	and the same of the same of the same of	and as should make a day	in and place and di	a to the cause/s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1	29c. Licens	se number	29	d. Date signed (Mor	th, Day, Year)
•	0		Dracell-	Corate ms	D3	5763	J.	corewrey.	20,2006
1			30, Name and address of person who	completed cause of death (Item 23a) (Ty 5505 Hopkins R	pe, Print)	1:0-1-	Be Himan	o Md o	12 2//
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	sayview	-Ircle	Cavillion	1	1004
	Regist		FEB 2 1 2	2006 Alexan A.	A grade				

			For State Registrar	State o	f Maryland		rtment of H			Reg. No. 0	16	04945
	Physic /Medi		1. Decedent's Name (First, Middle, ELLA MARII	E ALLEI					2. Date of De Month FEBRUA	ARY 19th	2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, ST. AGNES MEI	give street and nur DICAL CI	mber) EN T ER		BALT	Location of Death			ty of Death / A	
	Funeral Director		218-28-2798	1. Sex 1 ☐ M X (X)F	7. Age (In yrs. Ia 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year) 5/1927	9. Birthp Court	place (State or Foreign htry) CAROLINA
	Maryland -f show led at	tor	Usual Residence of Decedent	Ą	10c. City	BALT	cation IMORE C	ITY				10d. Inside City Limits Yes 2 □ No
	with the 3s or 28s	Funeral Director	10e. Street and Number 1230 SEMINOLI	E AVENUI	 E		10f. Zip Code 2122	9		10g. Citizen of USA	What Cou	ntry?
	036 urs after deett ai', or items 2	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 X ∏No ve		Vas Decedent of H f Yes, specify Cuba i ☐ Yes 2 ☐ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Bt	ice - Americack, White,	etc.
	laryland 21215-0036 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-1 show aumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 9TH	Education grade completed) College (1	1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired KER	during most of wor	rking	16b. Kind of PHARM		dustry
	Maryland of 2 should be file lith and Mental Hy, 27 is marked other traumatic event,	To Be (17. Father's Name (First, Middle, La SIDNEY POPI					18. Mother's Nar	ne (First, Middle, ETTA E	Maiden Suma	ime)	
	≥ 5€25		19a. Informant's Name/Relationshi	(Type, Print) / DAUG		512						, MD 2121
	Baltimore, permit. Pages 1 er Depertment of Hea mportent: if Item in injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		C C	ametery crer	sition (Name of natory or other place M. PK. (EM. 2/	25/06	WINDS		own, State ILL, MD
1	Baltimore permit. Pages 1 Depertment of H importent: if ite any injury or ot page.		21. Signature of Foreral Service Li	1/8.	Nown	4 -4	Name and Address	ERTY HE	TGHTS A	VE.		
•	Pnysician /Medical		23a. PACL In rithe disease, or conditions and tailure. List of limmed Cause (Final diseas or condition resulting in death)	_a C	caused the dead each line. EREBR (or as a consequ	OVA	er the mode of dyin	g, such as cardiad	or respiratory and	rest,		Approximate Interval Between Onset and Death TWO WECKS
-	ate be executed the burlal-transit and the burlal-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ							
77	ecords, P.O. Box 68760, iaw requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live b	tcome of pregnal birth 2 Fetal nant at time of de own	death 3	Ectopic pregnancy	,			ate of deliv	ery Day Year
V	dS, P.	þ	Part II. Other significant condition RENAL			ulting in the u	nderlying cause giv	en in Part I.		obacco use co		he cause of death?
7	o - 2	Completed	HYPE	RTENS	10N				24a. Was autor perfo 1 Yes	rmed?	. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
7	of Vital F Physician: Th this certificate rai director, peg	BeC	25. Was case referred to medical examiner?	10-3-3-1			J Ou		ath (Check only o		10 163	ZIZINO
	Phys Phys this rat di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Notatural 5 Pending 2 Accident investiga	28a. Date (Mon	Inpatient 2 🗆 I of Injury th, Day Year)	28b. Time of Injury	28c. Injur Wor	4 Nursing r	dome 5 ☐ Resident 128d. Describe I			(y)
	Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Nun vn. State)	nber or Rur	al Route Number,
	ne Hospit n 24 hour ne Funere	edical ((Check only one) Cartifier 1 X Cartifying (Check only one)	Physician: To the caminer: On the b and man	asis of examinat ner stated.	wedge death ion and/or in	t anounts that the trivestigation, in my o	na, date and plane pinion, death occu	and due to the urred at the time,	nause(s) and n date and place	and due t	tale.t. o the cause(s)
	To t withi To th	×	29b. Signature and title of certifier	ATTE	NBIN	9	29c. Licens			29d. Date sign		19 th 2006
	lê		30. Name and address of person w	ho completed caus	se of death (Item	23a) (Type, 49NES						
	- St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 1	2006	egistrar's Signat	ture	edi					

CARLOS ALVAREZ 06-01244 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#13, perFH C852, 2/21/06 TT enartment of Health and Mental Hygiene Unpend item#23a, FH 27, 25a-1, pen E 233, 279/06 TT RKD 1- State Registanend Item#28aperME, G853, 03/16/06/16bite of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician **FEBRUARY** 18, 2006 8:50A. 4a. Facility Name (If not institution, give street and number) Alvarez /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE ROSEDALE FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 158.M 2□ F Yrs. 24 Mary land Director 213-15-5194 May 15, 1981 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or itame 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director WD Bathmore Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21236 12. Was Decedent Ever in U.S. Armed Forces? 1932 Belfidge Road USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1, □Yes 2 □ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 Yes 25 No Specify: Hispanic Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other than r traumatic avent, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Plumber Steam Filter Apprentice Poole Kent Company
18. Mother's Name (First, Middle, Maiden Sumame) 12 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Gomez G. 2 Jaime Alvarez Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 is any injury or other tra 3403 Roselow Avenue Ballymore Manyland 21214

Log of Disposition (Name of Date 20c. Location City or Town, State Jaime G. Alvarez 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evens Furepel Chapel-Bel Air Feb 23, 2006 Forest Hill, Maryland 22. Name and Address of Facility Evans chapel of memories 21. Signature of Funeral Service Licensee Condrae h. ME. Maryland 21234 adde 8800 Harford Boad-Packville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic and alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the e 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 212 No 3 ☐ Probabiy 4 ☐ Unknown Cocaine use 1 🗌 Yes been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes certificate 2 🗆 No efter death.

Diractor: After this certific
Jin by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ves 2 No 1 Inpatient 2 YER/Outpatient 3 DOA မှ 28c. Injury at Work? 28a. Date of Injury (Mon**ing** Pay Year) nd 2/16/2006 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending Injury 1 Natural Fnd 7:45AM 1 ☐ Yes 2 No investigation 2 ☐ Accident 6 X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7932 Belridge Rd. 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Apt. J Nottingham, MD To the Hospital o within 24 hours eff To the Funarel Di completely filled in Found: Residence (apartment) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signs ture and title of certifier FEBRUARY 19, 2006 -AVV) O.C.M.E. Mumpme IN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 111 PENN STREET BALTIMORE, MARYLAND 21201 271 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12006 Lois Kay Allen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner mosical mnie 15 Baltimera Washington 1 em Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2X F Yrs MD 220-76-1957 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2X No Directo MDAnne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 260 Glen Gary Garth 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2CXNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Richard Allen, Jr. Carol Marie Butnam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 Spa Road; Annapolis, MD 21401 Mrs. Susan Weisberger/caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Memorial 2-22-2006 Easton, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licenses 1 Second Ave SW; Glen Burnie, MD 21061 Ma1357 ark 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 5 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

inding physicien and use as the burial-trar

sete has been signed by the attending page 2 should be deteched for use as

certificete

(his

death.

within 24 hours a To the Funeral L

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health end Mental Hygiene. Important: if item 27 is marked other then "natural; or iteme 23a or 28a-f ehow with injury or other treumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Certification: To Be

25. Was case referred to medical examiner? 1 Yes 25 No

24a. Was an

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

performed? Yes 25 No 25 No 1 Yes 26. Place of Death Check only one

Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

6 Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

> The Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causala) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of gertifier

20s Certifie

Medical

State Registrar

29c. License number

29d. Dale signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUR 3 01 (0K

31. Date filed (Month, Day, Year) FEB 2

32 Registrar's Signature

			1 - For State Registrar	State of Ma	ırylar				ealth a		F	Reg. No	HILLIA		049	40
11, 5	Physici		Decedent's Name (First, Middle, Last) INDYE		L.		AB	ERBA	СН	1	Date of Dea Month FEBRUA		ĺ8, 2̈́0̇̃	შ6	3. Time of 2:35	Death A M
No.	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)			4b. City,	Town, or	Location of	Death			County of E			
79		À.	23 STONEHENGE CIR						BALTIM						ALTIMO	
	Funeral Director		5. Social Security Number 6. Sex 086-03-0913	7. Age	(In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under 2	Min.	B. Date of Birth (Month, Day FEB.8,	1917	7	Birthpl Count	ace (State or ry) NY	_
	yland Now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	d. Inside Cit	•
	Ba-t el	Director	MD BALTI	MORE		BALT	rimor	E							1 🗍 Yes	2 No
	with th	Dire	10e. Street and Number 23 STONEHENGE CIF	OCLE #4			10f. Zip	Code	212	วกุณ		10g. Cit	izen of What	Count	ry? USA	
	ne 23	Funerai		12. Was Decedent B	ver in U	I.S. 13. V	Was Dece	dent of Hi			ify Yes or No- ican, etc.)		14. Race - A		n Indian,	
21215-0036	d within 72 hours after death with the Maryland Jiene. I then "neturel", or iteme 23e or 28e-t ehow I'n Mudical Ezanië et must be notille i et	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1	f Yes, spe 1 □ Yes		n, Mexican, Specify:	Puerto R	ican, etc.)		Black, V Specify:	/hite, e	white	
5	72 hc	etec	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Deced (Give	kind of wo	rk done d	during most	of working	7	16b. K	ind of Busine	ss/Ind	ustry	
121	within sne.	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5	+)		ро <i>кот и</i> [СЕ М					VEN	NDING			
ק ק	Hygin Hygin	Be Co	17. Father's Name (First, Middle, Last)			0111		11.11.10		's Name	First, Middle,					
Maryland	ould be Mental arked c	To B	JOSEPH	MAY	'ER		LESNI		MOL				THER		BIF	RSH
Mar	s 1 and 2 should if Heelth and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Ty) MARLA LEWIS / DAU	pe, <i>Print)</i> JGHTER			•	,			Route Numbe				Code)	
	Heeli Heeli tem 2 other	1	20a. Method of Disposition	Juillen	20b. F	Place of Dispo	sition (Na	me of		Da			cation - City	_	vn, State	
E E	Page ent o nt: it ry or		1 🕅 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State		cemetery, crer R SINA]				2/20/	2006	OV	VINGS	MIL	LS, ME)
Baltimore,	pemit. Pa Deportmen Important: any injury		21. Signature of Signature Signature of Signature Of Sign	96		22	. Name ar	nd Addres	s of Facility	SOL	LEVIÑ					208
100			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused ne cause on each lin	the deat										Approximate Interval Betw Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			ul infe	retio-		,						Lhaurs	700(1)
8760, <	Examine and spirial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as a Due to (or as a Due to (or as a	0000000	uence of):	diserv							3	jer	
P.O. Box 68	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	al death 3	Ectopic p						23d. Date of Month		-	ear
ras, r.	The law requires that the ste hes been signed by th bage 2 should be detache	þ	Part II. Dther significant conditions cor			-		-					se contribut XNo 3□			
Division of Vital Records,	The law requir sate hes been si page 2 should a	Completed	hypesteuson hypestopiden	Le .						_	24a. Was a autop perfor	SV	24b. Were prior death	to com	sy findings a apletion of ca 2 No	vailable iuse of
Ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	Check only o	пө)				
on of	Phys this ral dii	ion; To	27. Manner of Death 1 ⊠Natural 5 □ Pending	ospitaf: 1 ☐ Inpatie 28a. Date of fnjur (Month, Day	v .	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 🗆 Nuis	28	e 5 Resid			Specify)	
DIVISI	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At h . (Specii	ome, farm, str	eet, factor				If. Location (S City or Tow			Rural	Route Numb	007,
	ne Hospit n 24 hours ne Funera	edicai (29a. Certifier 1 M. Certifying Phys (Check only one) 2 Medical Examin		examina											
	To the within To the Comp	Me	29b. Signature and title of certifier	-]	c. License			4		te signed (M	onth, E	ay, Year)	
)			* Killerd OSCI	5. hD				020	604			2/	119/06			
	4		30. Name and address of person who co	mpleted cause of de	ath (Iter	r 23a) (Type, Falls Rd	Print) Lulhe	wile, 1	nd 2109	53						
7	Sta Registr		Rulerd A. Beg. 5 31. Date filed (Month, Day, Year) FEB 2 1 200	32 Registra	r's Signa	ature de	de									

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar State Reg. No.								
-	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) BETTY JANE BROWN BROWN 2. Date of Death Month Day Year FEBRUARY 16 2006 3. 50PM 4c. County of Death 4c. County of Death								
	Funeral Director	CI	HARBOR HOSPITAL CENTER BALTIMORE N/A 5. Social Security Number 259-38-0627 N/A 8. Date of Birth (Month, Day, Year) Months Days Hours Min. N/A 9. Birthplace (State or Foreign Country) Months Days Hours Min. N/A 1 May 7, 1924 Tennessee								
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examinational Le notified at ance.	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No No 10d. Insi								
	Pnysician /Medical Examiner	e	Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
). Box 68760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes VENo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								
Division of Vital Records, P.O.	Attending Physician: or death. ector: After this certification by the funeral director,	Thy Pertension Thy Pertension									
)	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier PESOOO FEBRUARY 16 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PRABHAKAR, 3001, S. HANOVER STREET, BALTIMORE, MARYLAND-21225								
-	Sta , Registi		DR. PRAISHARAR, 3001, S. HANOVER STREET, BACTIMORE, TIME JULIA 131. Date filed (Month, Day, Year) FEB 2 1 2006 See The Company of the Compan								

		-	For State Registrar	State of M		l / Depa		of H	ealth a				006	049	150
	Physicia		1. Decedent's Name (First, Middle, Last Richard Leroy	_	r]	2. Date of De Month Cebrua	ath ry 1	9 2 ^Y ear		of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o				ounty of Dea		
	CAGIIIII	C'	Westminster Nur	sing &	Rehal	o	Wes	tmi	nste	r			rroll	L	
	Funeral Director		370 30 3303 2		Age (In yrs. Ia: 79	st birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bir (Month, Da Nov 3	0 19	9. Bi	rthplace (Sta Country) C	te or Foreign
_	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	e City Limits
	Maryl f sho	ō	Md Carroll		Wes	stmin	ster							1 🗆 Y	res X□No
	with the 3e or 28a	Funeral Director	10e. Street and Number 3432 Sykesville	Road			10f. Zip 211					10g. Citize	en of What C	Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Exacilities at once.	by Funera	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 N If Yes, Give Year or Dates	s? X No		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, Wh		1,
21215-0036	bour	edt	15. Decedent's Ede	cation		16a. Deced	ient's Usua	l Occupa	ition			16b. Kind	d of Busines:	s/Industry	
215	hin 72 s. nn "ng	plet	(Specify only highest grad Elementary/Secondary (0-12)	(1-40 College	or 5+)		kind of wor DO NOT us				ng	_		3	
7	er the	Completed	12			ven	ding	ma						Amer	ıca
Maryland	uld be filed Aental Hygie irked other itic event, II	To Be (17. Father's Name (First, Middle, Last) Frederick Baker								de Gro		iumame)		
	nd 2 should alth and Men 27 Is marke r treumatic		19a. Informant's Name/Relationship (T) Judith Baker (s				•				Noute Numb				21157
altimore,	es 1 a of Het litem		20a. Method of Disposition 1 Burial 2 XCremation 3	Removal from Stat		nce of Dispo							•	r Town, State	
Ĕ	Pages ment of ant: If it ury or c		'4 □ Donation 5 □ Other (Specify		All	Coun					1-06				
Balt	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licens Page Houge	werk in	tree						ight F kesvil				Chape
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caus ine caus on each	ed the death.		,								mate Between nd Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or a	as a conseque	ence of):	-1	/a	rn	lur	Dires	ne		25	'n_
1	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Durio (or t	es a conseque	ence of):								15	yr_
,097	icate be executed physician and s the burial-transit	cal Exa	resulting in death) Last	d. Due to for a	as a conseque	ence of):								129	iun
89	rtifical ng phy as th	Medi	IE ECMAI C.							- C			-	9	
.O. Box	The law requires that the death certificat to has been signed by the attending phy bage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal of at time of dea	death 3	Ectopic pr Other (sp					23	3d. Date of de Month	elivery Day	Year
Ω.	luires that the de signed by the lid be detached	by	Part II. Other significant conditions or	entributing to death	n but not resul	iting in the u	nderlying c	ause give	en in Part I		23e. Did t	_		to the cause Probably 4	
Records,	The law requirate has been spage 2 should	ompleted									24a. Was auto perfo	psy ormed?	24b. Were a prior to death?		ngs available of cause of
Vital		C	25. Was case referred to medical						26. Place	of Deat	(Check only				
of V	y s	To B	examiner? 1 □ Yes 2 No	Hospital: 1 🗌 Inpa		R/Outpatien			420		me 5□Resi			ecify)	
ion o	ding n. After fune	ertification;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Ir (Month, I	njury Day Ye <i>ar)</i>	28b. Time of Injury	f 2	8c. Injury Work 1 🔲 `	yat k? Yes 2□	- 1	28d. Describe	how injury	occurred		
Division	el or Attenos after death	Sertific	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory	, office			28f. Location (City or To		Number or I	Rural Route h	Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medicel Exam	/sicien: To the be iner: On the basis and manner	s of examination stated.	on and/or in	vestigation	, in my of	pinion, dea	ith occur	red at the time,	date and p	place, and du	ue to the caus	
	To th withir To th comp	Me	29b. Signature and title of certifier	Midd	litm	lus	7	License	o number	13	M	29d. Date	signed (Mor	200	(c)
	6		30. Name and address of person who o	completed cause of	death (Item	23a) (Type,	Print)	lesto	nin (ter	M	02	1152	?	
	Sta , Registi		31. Date filed (Month, Day, Year) FEB 2 1 20		istrar's Signati	ure	ede)					
				-											

Ensure All Copies Are Legible. Please Type or Print in Black Amend Item 28f per ME, G8 State of Maryland / D Amend Items 25,28a-f per ME, G alth and Mental Hygiene 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:05 P M Physician Michelle Eileen Bortner Varyory 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Burnic Baltimore Ubshington Kediral Conter Glen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2 X F Yrs. 35 Director 214-11-2637 1970 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 206 5th. Ave. S.W. 21061 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ပ Bryan Mitchell Livesay Linda Eileen Claffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bortner, Jr / Husband 206 5th Ave S.W. Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages in Department of Himportant: If ite any injury or ot once. Jan. 21. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Glen Haven Mem. Park 2006 Glen Burnie, MD 21. Signature of Fun val Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy S.E. Glen Burnie, MD IN 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Encept **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical MEDICAL EXAMINER the attending pl ON APPROVEDE IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy CERTIF in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 4 Olinknown 1 Yes 2 No 3 Probably Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ✓ 10 24a. Was an s certificate has lirector, page 2: autopsy performed?

1 Yes 2 2 No or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Impatient 2 ER/Outpatient 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Found 1345 1 Natural 5 Pending death. investigation 01/08/2006 1 ☐ Yes 2 No Unknown 2 Accident within 24 hours efter death To the Funerei Director: completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Boute Number 205 City or Town, State) MD 5th Ave 3 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide home To the Hospital At **Clen** Burnie 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number who completed cause of death (Item 23a) (Type, Print) MAKY A GAVIRYA 30 31. Date filed (Month, Day, Year) FEB 2 1 200 32. Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

Brock

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2006 FEBRUARY 18, 1:30 P BOYER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2\ F Months Days Hours 216-01-1001 91 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked othar than "natural", or frams 23e or 28a-f show traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Bel Air Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive, Apt. 21014 U.S.A. Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural" ~ "... any increase." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Marsheck Daisy Gover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11906 Cedar Lane, Kingsville, MD Mrs. Betty Baumann (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l 2/21/2006 Timonium, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buan a. We llean 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Recurren 1201V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown neumoni Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has 1 Yes 24 No I or Attending Physician: after death. Diractor: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 FB/Outpatient 3 DOA 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funaral D 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ebruary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MANUEL LAZATIN 8 LAW STREET ABERDEEN, MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 FFB 2 1 Registrar

DHMH 17 Rev 1/2001

			riease	Type of Piliting					
			For State	State of Marylan		ent of Health and I	1		01.953
			Registrar		Certifica	ate of Death	Reg. No	o	La Fina et Dooth
	Physici	an	1. Decedent's Name (First, Middle, La	(st)				ay Year	3. Time of Death
	/Medic		THULY 15	cheuettu			Feb 18	2006	1.001. "
	Examin	er	4a. Facility Name (If not Institution, gi	re street and number)	4b. Ci	ty, Town, or Location of Death	_	C. County of Death	100=
			FRANKIN WO	Sex 7. Age (In yrs	lest highday) If Uni	DHCD MORA der 1 Year If Under 24 Hrs.		1	
	Funeral Director			1 M 2 DF	Yrs. Month		8. Date of Birth (Month, Day, Year	1REN	place (State or Foreign htry)
			Usual Residence of Decedent				12/4/0	1/1/10	700, 70] -
	yland		10a. State 10b. County	10c. Cit	y, Town or Location	1		1	0d. Inside City Limits
	e-f s	ţċ	MD (arrol		Tan	ey town			1 ☐ Yes 2 XNo
4	or 28	Director	10e. Street and Number	21 21	101.	Zip d ode	10g. C	itizen of What Cour	ntry?
1	De liled within 72 nours after death with the Maryland tal Hygiene. At Hygiene of other than "natural", or iteme 23a or 28e-f show event, the Medical Examinar must be notified at	al	3013 Menge	s Mill Kd.		21787		USA	Jin.
	eme eme	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	 Race - Americ Black, Whita, 	an Indian, etc.
ရှ ်	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1	211 No Specify:		Specify: /	rite
500	illed within 72 hours affer Hygiene. Ither than "natural", or ite ant, the Medical Exantion		3 Widowed 4 Divorced	Year or Dates:	160 Donadonio II	evel Occupation	16h 1	Kind of Business/Inc	ductor.
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ָר ע ס	Hygi Hygi Sther	ပိ	17. Father's Name (First, Middlen Las	1)	Horar		ne (First, Middle, Maide		
	ental ental ked c	To Be	Pietro Pin	1		Mar	" Mana	1150	
<u> </u>	z should be and Menta le marked sumatic ev	-	19a. Informant's Name/Relationship		19b. Mailing Addre	ess (Street and Number or Ru	ra Route Number, City	or Town, State, Zip	Code)
2	ulth a 27 le		Frank Bonodet	ta - 500	2013 M	enges Mill	To Tanci	. trunk	1021787
ē.	Fages 1 arment of Hes ant: If Item ury or othe		20a. Method of Disposition		Place of Disposition (fi	Name of or other place)	Date 20c.	ocation - City or To	own, State
Ë ,	permit. Pages Department of Important: If It any injury or o		1 Desurial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Spec	THemoval from State	mu Valley 1	Mul Godans 21	22/06 Ti	MARION	MO
baltimor	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	nsee		and Address of Facility	I TIMORE	MO 21	234.
מ	Depa Impo any ii		Kimbely ()	3x No Che		Fuveral Cha	ROL SKOT	MEFORE	ICD
			23a. Part I. Enter the disease, ir conshock, or heart failure. Let only	plicate no that caused the deat	h. Do not enter the m	node of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	ATHERO				EASE	Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):				
	Examiner		Sequentially list conditions,	b. COP	ONART	ARTERY	DISE	ASE	
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V	be executed icien and purial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):			-	
o,	sicient: The law requires that the death certificate be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	calE		20010 (0) 20 20 30 40	,				
	phys phys s the			_ d.					
X	ine law requires marme death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delive	erv
ŏ	atter 1 for t	clar	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of d		pregnancy (specify)		Month	Day Year
	y the	hysl	9 Unknown	9□ Unknown					
L	s mar ned t	by P	Part II. Other significant conditions		ulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the	he cause of death?
3	quire an sig uld b		DIA	BETES			1 ☐ Yes 2	2XNo 3□Prob	pably 4 □Unknown
ecords,	s bee	olet					24a. Was an	24b. Were auto	opsy findings available impletion of cause of
ב פֿ	te ha	ompleted					autopsy performed? 1 ☐ Yes 2 🗷 N	death?	2XNo
	tiffical tor, p	C	25. Was case referred to medical			26. Place of Dea	th (Check only one)	0 1 10100	
> 3	rnysicien: this certific al director,	0 8	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3		ome 5 Residence	6 ☐Other (Specif	5 y)
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IO HOISINIO	er de recto by th	tific	3 Suicide 6 Could not determined			tory, office	28f. Location (Street a City or Town, Sta	nd Number or Rura te)	al Route Number,
5	rs aft rs aft et Di ed in	Certification:	<i>p</i> .				bl.		
	To the nospital or Attending Prysicient, within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier Certifying P	hysician: To the best of my kno miner: On the basis of examina	owledge, death occurration and/or investigat	ad at the time, date and place ion, in my opinion, death occu	, and due to the cause(irred at the time, date ar	s) and manner as s	tated. o the cause(s)
1	the F	Med	one)	and manner stated.		29c. License number	20d D	ate signed (Month,	Day Year
3	To	<	29b. Signature and title of certifier	111		D 4000 8		1) A 1 "	
			100	sholl		D 7000 () +	12010	6
	(0)		30. Name and address of person who	completed cause of death (Item	TO 23a) (Type, Print)	SOLAPE DA	BAITIM	ORE MO	21737
1=	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	SQUARE DA)	/	1-1-1
	Sta Registr		EED 0 1 000	a de	honette D				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Feb. 18 2006 Roger William Bruce 7:00 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2209 Timothy Drive Carroll 5. Social Security Number 9. Birthplace (State or Foreign Country)
PA 7. Age (In yrs. last birthday) **Funeral** XXM 2 F 72 Yrs. Director 219-28-8855 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2209 Timothy Drive 21157 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (BYes 2 □ No 1954 – If Yes, Give Year or Dates: 1956 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Simulation Elementary/Secondary (0-12) College (1-4or 5+) Link Tactical Division Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Depertment of Health and Mental Hy Important: If flem 27 is marked oth eny linjury or other treumatic event sone. Frederick Bruce Jessie Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis S. Bruce 2209 Timothy Drive Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State South Carroll Crematory Dec. 19, 2006 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part 1. Privater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition resulting in death) cropharynx **Physician** ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by None 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 15552 2/17/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 21157 M.D. Canter 5+ 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 2 1 2006

			1 - For State Registrar	State of Marylan	•	irtment of I			iene	6 0495	5
			Decedent's Name (First, Middle, Last,)				2. Date of Deat	h	3. Time of Dea	th
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	/Medio Examir		4a. Facility Name (If not institution, give				or Location of Dea		4c. County of		
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	Funeral		5. Social Security Number 6. Sec			If Under 1 Year		8. Date of Birth		9. Birtholace (State or For	eign
	Director		214-58-8779]M 2□F	55 Yrs.	Months Days	Hours Min	Nov. 22	1950	Maryland	
	ъ		Usual Residence of Decedent								
	how	١. ا	10a. State 10b. County	10c. City	r, Town or Loc	cation				10d. Inside City Lie	
	e Me	cto	Maryland Baltimore	Tov	vson					1 □ Yes 2√X	NO
	th th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	•	
	15 Wi	ai	8720 Emge Road			2123	4		U.S.	Α.	
	dea	ne	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of I	Hispanic Origin? (Specify Yes or No- nto Rican, etc.)		- American Indian, White, etc.	
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ğ	in in in in in in in in in in in in in i	q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		A.				White	
Ϋ́	natu Office	Completed by Funeral	15. Decedent's Edu (Specify only highest grade		(Give i	ent's Usual Occu kind of work done	during most of wo	orking	16b. Kind of Busi	iness/Industry	
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Maryland 21215-0036	be f	Be	Edward		D =			ille (Filst, Wildule, A		lev	
Ĕ	J Mer J Mer nark	၉	19a. Informant's Name/Relationship (Ty	0-1-0	Borman		Janet	ural Route Number,			
ā	h and 7 le r		Christina Borman					imore, Ma	•		
e)	1 and Healt em 2 ther		20a. Method of Disposition		1					ity or Town, State	
Ö	T It of a		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	IOIIIOVAI IIOIII SIAIO		sition (Name of eatory or other pla	1 001	cuary	EUG. EUGGHOIT U	ny or rown, oldio	
≓਼	ther tant		4 □Donation 5 □ Other (Specify)			ematory	21,2	2006	Baltimor	e, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 ie marked other than "natural", or items 23e or 28s-f show any figury or other traumatic event, the Madical Examinar must be notified at ance.		21. Signature of Funeral Service bicers		// 24	J. Dabrov	wski/Cho	nacki Fur	neral Ho	mes P.A.	
	an z a d		1 Jash 1	· Keynach	6	<u>.005 Dunc</u>	dalk Ave.	Baltimo	re, Mary	Tand 21224	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each line	O ()	er the mode or dy	ng, such as cardia	c or respiratory arre	ist,	Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	1110	1	1 Acc	· Co +	_	
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o. _	e de the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5⊔	Other (specify) _				ŕ	
<u>.</u>	that the de led by the e detached f	P	Part II. Other significant conditions cor	tributing to death but not resu	Iting in the un	derhing cause on	von in Part I	23e Did tob	acco use contrib	ute to the cause of death	
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Ē	ing P liter t	ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	rk?	28d. Describe ho	w injury occurred	1	
<u> </u>	ttendi death. ctor: A / the fu	cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2 □No				
Ξ	or Ati	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre)	et, factory, office		28f. Location (Str City or Town		or Rural Route Number,	
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	Hosi 24 ho Fune fely fi	Medicai	29a. Certifier 10 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowner: On the basis of examinat	viedge, death ion and/or inv	occurred at the ti estigation, in my	me, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manr te and place, and	ner as stated. d due to the cause(s)	
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DHMH 17 Rev 1/2001

State

Registrar

FEB 2 1 2006

State of Maryland / Department of Health and Mental Hygiene ()

04957

		Certificate of Death Reg. No.												
			1. Decedent's Name (First, Middl	le, Last)							2. Date of De	ath	Voor	3. Time of Death
	Physic /Medi		Dorothy G.	Brooks							Februa	ry ^{Day} 5,	2006	7:15 am
*	Exami		4a. Facility Name (If not institution	n, give street and numb	er)				4b. City, To	own, or Lo	cation of Deat		y of Death	
			Maryland Mason	ic Home					Hunt		y	Balt	imore	
	Funeral Director		5. Social Security Number 212-07-8137	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. I	ast birth Yı	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept.	ž th 27, 191	9. Birthpla Count Mai	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town	or Location						10	d. Inside City Limits
	/anyla	5	Md. Balti		,		gham							1 ☐ Yes 2 ☒ No
	the N	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Count	v?
	ath with	ra D	4334 Penn Ave.				2	123					USA	
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam net must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	⊠ No	S.	13. Was Decede If Yes, speci 1 ☐ Yes 2				cify Yes or No Ricen, etc.)	Specia	ce - America ick, White, e fy: Wh	
2 2	72 hc	Completed by	15. Deceden (Specify only higher	t's Education		16a. D	ecedent's Usual	Occup	ation during mos	st of workir	na	16b. Kind of E	Business/Indu	ıstry
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anc	od ott	Be	17. Father's Name (First, Middle, James B. Norr									, Maiden Surnai	ne)	
Ë	hould d Mei merke	2	19a. Informant's Name/Relations			10h A	Mailing Address	/Stroot			Christ		Stato Zin (Codo)
, Σa	and 2 seath en 127 is i		Mr. Robert N.R		Son		334 Peni							
Baltimore, Maryland 21215-0020	Pages 1		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		to CE	metery,	risposition (Nam crematory or oth od Ceme	her pla		2	Date 1-18-06	20c. Location Balti	- City or Tow MOIE,	
Balt	permit. Departn Importe any Inju		21. Signature of Funeral Service	Licensee	2			Tot	noor l	Funer		e, Inc. d. 2120	/ ₁	
			23a. Part 1 Enter the disease, or	complications that caus	ed the death	Do no								Approximate nterval Between
	Physician		snock, or neart failure. List	3a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. The disease or condition is ultimated by the condition is ultimated by the cause of the cause (Final sease or condition is ultimated by the condition is ultimated by the cause of the cause (Final sease or condition is ultimated by the cause of the cau										Onset and Death
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	ficete be executed physicien and st the burial-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0			nsequence of):							
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D	deat deat	sici	Part II. Other significant conditio	ns contributing to death	but not resul	ting in th	ne underlying ce	use giv	en in Part I		23b. Did 1	tobacco use co	ntribute to t	he cause of death?
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Jivision of	tending Physideath. tor: After this crithe funerel dir	Certification:	27. Manner of Death 1 SNaturel 5 ☐ Pending investig	g 28a. Date of Ir (Month, L	ijury Day Year)	28b. Tim Inju	ie of 28 ry M	c. Injur Wor	yat k? Yes 2 □		8d. Describe t	now injury occur	red	
	Attensar deat ector: by the	iffica	3 Suicide 6 Could n	not be 28e. Place of I	njury - At hor etc. (Specify)	ne, farm	, street, factory,	office		2	8f. Location (5 City or Tox	Street and Numi	ber or Rural I	Route Number,
5	tai or ris afte al Dir led in			building,							0.0, 0. 70.	, 0.2.0,		
	25. Was case referred to medical examiner? 1								ne, date an pinion, dea	d place, ar th occurre	nd due to the d d at the time,	cause(s) and m date and place,	anner as stat and due to t	ed. he cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	0			29c.	Licens	e number	/		29d. Date signe		ay, Year)
			P.t.	Telets,	ms.			1) 0	-146	X		2-16-0	6	
	3		30. Name and address of person v	who completed cause of	death (Item:	23a) (Ty	pe, Print) Benh	57	- B	cels	, ns	2-16-0 d 21.	224	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	ire,	w) a		• 25		1	1		
	Registr	ar	FEB 2 1 200	6 Minus	Sales A	14								

Please Type or Print in Black Indelible Ink. El	nsure All Copies Are Legible.
State of Maryland / Department of Heal	alth and Mental Hygiene

			1 = For State Registrar		State of M	aryland		artment o <i>rtificate</i>				ene g. No.	6	049	58
	Physici		1. Decedent's Nam Emma N.	e (First, Middle, La: Bowland	st)						2. Date of Death		2006	3. Time of 1:49	Death A M
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, To		ocation of Death		4c. Count			
	Funeral Director		5. Social Security N 292-18-4	lumber 6. S		91	st birthday) Yrs.	If Under 1	Year I	f Under 24 Hrs. Hours Min.	8. Date of Birth July 27,	J	9. Birth	olace (State ontry) Ohi	
	land		Usual Residence o 10a. State	f Decedent 10b. County		10c. City,	Town or Lo	cation						10d. Inside C	ity Limits
	a-f eh	ctor	MD	Baltimore	9	Park	ville							1 ☐ Yes	2 No
	h with the	Funeral Director	10e. Street and Nu 8810 Wal	mber ther Blv	d. #1202			10f. Zip Co				og. Citizen of USA	What Cou	ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or iteme 23a or 28a-f ehow appringut or other traumatic event, the Medical Examinating must be notified at ance.	þ	11. Marital Status 1 Never Marr 3 Widowed	ied 2∰Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 Pes 2 V If Yes, Give Year or Dates:	Ever in U.S No		Vas Deceden f Yes, specify I □ Yes 2□		panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ick, White,	can Indian, etc. ite	
21215-0036	within 72 he iene. Then "netu	Completed	(Spec	15. Decedent's Ecify only highest gra	ducation de completed) College (1-4or 5+	5+)	16a. Deced (Give life. L		Occupation done dur retired)	on ing most of work	ang	neb.Kind of E Baltimo Public	ore C	ounty	
land 2	ld be filed ental Hygi ked other ic event, I	To Be Co		(First, Middle, Last)						8. Mother's Nam	e (First, Middle, N	faiden Sumai	me)		
Maryland	and 2 should salth and Men n 27 is marke			ame/Relationship (band		ng Address (S Walth			ral Route Number, 1202; Pai				
Baltimore,	Pages 1 and of Height: If item		20a. Method of Dis 1 Burial 2 4 Donation	Cremation 3	Removal from State O entonbment	Cei	m <i>etery, cre</i> n	sition (Name natory or othe emory	r place)	en 2/20		Whites			
Balti	permit. Departminents importa any inju			urleral Service Liger		1	22	. Name and A	Address			1050	York	Road D 2120)4
7	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	plications that cause one cause on each li a	entro	ence of):	er the mode o			or respiratory arre	est,		Approximal Interval Bet Onset and	ween
68760,	ficate be executed physicien and is the burial-transit	edicai Examiner	Sequentially list co if any, leading to ir cause. Enter Unde Cause (Disease or that initiated event: resulting in death)	S	cDue to (or as										
P.O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 24 9 Unknown	menths? ☑ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal of	death 3□	Ectopic pregi Other (speci		-			ate of deliv		Year
	quires that I n signed by uld be deta	þ	Part II. Other signi	ficant conditions o	ontnbuting to death b	out not resul	ting in the u	nderlying caus	se given	in Part I.	23e. Did tob	acco use con		he cause of o	
of Vital Records,	The ate h page	Completed									24a. Was ar autops perform 1 Yes 2	y	Were auto prior to co death? 1 Yes	opsy findings impletion of o	available cause of
Vita	Physicien: The this certificate har all director, page	o Be	25. Was case reference examiner?		Hospital:	005	R/Outpatien	4 2004	Other:		th (Check only one				
	ing Ph .r After th funeral	-	27. Manner of Deal 1 Natural 2 Accident		28a. Date of Inju (Month, Da	iry 2	28b. Time of Injury		Injury a Work?	Nursing Ho	ome 5 Reside 28d. Describe ho			ry)	
Division	in Pite	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of In	jury - At hon tc. (Specily)		eet, factory, o	ffice		28f. Location (Str City or Town		ber or Run	al Route Nun	nber,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Madical Exam	ysician: To the best ninar: On the basis of and manner st	of examination	ledge, death on and/or in	occurred at vestigation, in	my opin	date and place, ion, death occur	and due to the ca red at the time, da	use(s) and m ite and place,	anner as s and due t	stated. o the cause(s	s)
	To th within To th compli	Me	29b. Signature and	title of conflier	~~				icense n	_	25	d. Date signe			
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	13		700 1	ress of person who	completed cause of c	: meath (Item) نادیل	113	Blu)	P	Wholl	m	21234			
	Sta Registr		31. Date filed (Mor		32. Registr	rar's Signatu	ire	the							

			State of Maryland / Department of Health and Certificate of Death		iene 006	04959
			Decedent's Name (First, Middle, Last)	2. Date of Deat	th	3. Time of Death
	Physicia		Bernard Franklin Bull, Jr.	Februar	y 16,2006	12:00a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Dea	
			Brighten GARDENS OF TOWSON TOWSON, THO	21212	baltim	
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Hrs. 8. Date of Birth Min. (Month, Day)	Year) 9. Bir	thplace (State or Foreign buntry) ARYLAND
п	Director		218-22-1421 78 Yrs.	10-11-	27 m	ARYLAND
	and *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryli F sho	ō				1 ☐ Yes 2 ☐ No
	28e-	Director	Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	with 3e or		11922 Mays Chapel Road 21093		USA	
	ns 20	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin?	? (Specify Yes or No-	14. Race - Ame	
ယ	or Iter	교	1 Never Married 2 Married 1 Yes 2 No	uerto Hican, etc.)	Black, Whi	e, etc.
ğ	rel', c	1 by	3 ☑Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	White
2-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	working	16b. Kind of Business	/Industry
2	vithin ne. hen	d d	Elementary/Secondary (0-12) College (1-4or 5+)		Paint Com	nany
N N	iled v Hygie ther t nt, th			Name (First, Middle, I		parry
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If marked other than "neturel", or Items 23e or 28e-f show liter Z is marked other than "neturel", or Items 23e or 28e-f show other treumetic svent, It a Musical Examination as the multired at	o Be		_	allender	
<u> </u>	shoul of Me mark meti	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			Zip Code)
Š	nd 2 lith a 27 is r treu		Claire Skwirut / Daughter 11922 Mays Chapel Ro	oad Timon	ium. Md. 2	1093
ē,	s 1 a f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	
Ë	Pages nent of P nnt: If its ury or of		1 X Burial 2 Cremation 3 Hemoval from State	18/06	Baltimore,	Maryland
altimore,	permit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature Funeral Pervice Lightsee 22. Name and Address of Facility	-	1050 Y	ork Road
<u> </u>	89 1 2 8		Ruck Towson Funer			,Md.21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. Lisy only on cause on each line.	diac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SC .		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			1
	Lxammer	_	Sequentially list conditions, b. Justo for as a consolience of			
	led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury			
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8760,	cate be executed physician and the burial-transit	dlcal 8	d			
9	ifficating phy g phy as the	a)				
ŏ	th cer endin r use	N/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	•
P.O. Box	ed for	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
<u>Ч</u>	at the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Did to	bacco use contribute t	o the cause of death?
	Physicion: The law requires that the death certific this certificate has been signed by the attending ral director, page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in rare.	1 □ Y	1/	robably 4 Unknown
0.0	requ	Completed	Hung do man	_		utopsy findings available
3ec	8 8 8	ш	March Charles Andrews	24a. Was a autops performance of the control of	prior to death?	completion of cause of
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⋚	siciel certi irecto	o Be	examiner?	Death (Check only or ng Home 5 Resident	1/	11. Marie
ō	Phys or this oral di	J: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	Living.
ion	nding F ath. r: After e funer	atlo	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			V
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Number or R	ural Route Number,
	tel or A rs after el Dire	Cer				
	Hospi 4 hou Funer ely fiil	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or			
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Med	one) and manner stated. 29b. Signature and title of certifier 2 29c. License number	2	9d. Date signed (Mon	th, Day, Year)
	A W L	_	MINIMAN 130432	3 1	56 A	2006
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1.	00 11	1000
1	011		MOHN MD COMMIC 6701 N CHARLES 87	13AUT 11	MOLE 1	10 41204
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	FEB 2 1 2006 As As Aside			

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Gesting in death Last Due to (or as a consequence of): Due to (or as a consequence of):		7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	qa of):	er engine	1.		J years
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	Physic	ian	Decedent's Name (First, Middle, Last)			*-				2. Date of Dea		/, Xes	r_	3. Time	
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Ball	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service License	M014	420 Ro	Name and bert A. Visc	Address Pum Consin	of Facility phrey i Aven	Funera ue, Be	al Home/ ethesda,	Beth Mar	esda-Che yland 20	38¥4	Chase	, Inc.
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<u>α</u>	The law requires that the te has been signed by thi page 2 should be detached.	by Ph	Part II. Other significant conditions conf	ributing to death but not re	sulting in the ur	iderlying cau	use given	in Part I.		23e. Did to	bacco u	se contribute	to the	cause of	death?
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_	To the Hospital or Attending the Mospital of the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Physi	cian: To the best of my kno	owledge, death	occurred at	the time	date and	place, and	1 due to the c	ause(s)	and manner	as state	M.	2
	ne Ho in 24 t he Fui pletely	edicai	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	ation and/or inv	estigation, in	n my opin	ion, death	occurred	at the time, d	ate and	place, and d	ue to th	ne cause(s)
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	4	For	State of Ma	ryland			ealth and M	ental Hyg	giene	
	_]	State Registrar			Cert	ificate of L	Death		Reg. No.	04962
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Examine	7	A. Facility Name (If not institution, given the second of	reneral	HOSP (In yrs. las	i tal	ab, City, Town, or Bultiman If Under 1 Year	Location of Death	Auf 8. Date of Birth	4c. County of Dea	nth
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land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				10d. fnside City Limits
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h the	2	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
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036 urs after bil; or its	<u> </u>	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:		1	las Decedent of Hi Yes, specify Cuba □ Yes 2☐¥No	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: BL	ite, etc.
22 ho	31ed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give k	ent's Usual Occupa	during most of working	ng	16b. Kind of Busines	
/ · M -		Elementary/Secondary (0-12)	College (1-4or 5-		life. D	O NOT use retired)	1	MARYLAND	
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Iryla should I Man Manic a Imatic	2	19a. Informant's Name/Relationship			19b. Mailing	Address (Street a			r, City or Town, State,	Zip Code)
Ma Malth au 127 is 127 is	1	YVONNE TAYLOR	(SISTER)		2312	HAMILTO	ON AVENU	E BALT	CIMORE, MD	. 21214
Baltimore, Maryland ; permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg important; if item 27 is marked othe any Injury or other traumatic event, once.	The same of the	20a. Method of Disposition 1X Burial 2 Cremation 3 [4 ZDonation 5 Other (Speci				ition (Name of atory or other plac MEM . PA		21,20	20c. Location - City o	
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/Medical		resulting in death)	Due to (or as a	conseque	nce of):			3	N Wa	
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cords, P.O. Box (w requires that the death certif been signed by the attending should be detached for use a	ysician/iv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetaf d	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
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The lar	E /	1 Carrock 110	,	<u> </u>	***				rmed? prior to	completion of cause of
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or Att	Certification	3 ☐ Suicide 6 ☐ Could not determined	building, 9to	ry - At hom (Specify)	ne, farm, stre	et, factory, office		28f. Location (S	Street and Number or I vn. State)	Rural Route Number,
pitaf purs a purs a eral if	2	29a. Certifier 1/D Certifying P	hysician: To the best of	1000		occurred at the tim	no, data and place		1000 -	ac stated
24 hos Fun et-ly	edica		miner: On the basis of and manner sta	examination						
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29b. Signature and title of certifier				29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
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101	-	30. Name and address of person who			23а) (Турв, Г	Pript)	7		. /	/ 0
			ACHUKWI		D. 7	10 7 h	Ryland	Gene	ral Hos	pital
State Registra		31. Date filed (Month, Day, Year) FEB 2 1	32. Aegistra	ar's Signatu	ire	estis	\bigcirc		6	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5,8,18,20a-c,22 per fh 8834 4-12-06 vt

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item #9,11,12,15,16a&b,17,18,&19b,PER ANA BD G852
Registrar Registrar Registrar Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** Dennis Lee Creasy 2006 11:15 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner #16 51st St. Unit 202 Ocean City Worcester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 216-50-9819 8. Date of Birth (Month Day, Year) Funeral Days Min Months Hours 1 XM 2 ☐ F Director 57 5/26/1948 Virginia Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h County er then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at ty⊡Yes 2 □ No Maryland Worcester Ocean City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #16 51st St. Unit 202 USA 21842 12. Was Decedent Ever in U.S. Armed Forces? 1½□Yes 2□No If Yes, Give '67-71 Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk al Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) 12 Disabled unk none other traumatic event, unk 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Sumame) Be and Mental ! should be ို Ravmond CReasy Francis Kemper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) unk f Heelth 651 Otsego Street Karen Ellis/sister Havre de Grace, Md. 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5= 1 Burial 2 ** Fremation 3 Removal from State Depertment of Importent: if eny injury or once. 3-24-06 4 □Donation 5 NOther (Specify) In State R.A. Ferris & Co. West Chester, PA. 21. Signature of Funeral Service Licensee Ronald S. Wade Tarring-Cargo Funeral Home, P.A. 22. Name and Address of Facility
State Anatomy B S. Wade, Director Aberdeen, Md. 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** DIABETES MELLITUS SEVERAL YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): 68760, physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetef death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? ğ Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown certificate hes been signed rector, page 2 should be del Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Infury Naturaf 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 106241 2-15-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 SNOW ST. SNOW HILL, MD. 21863 DOROTHY HOLZNOZTH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

Pamela Callahan Faminer As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) As Facily Name (Free response), yes street and number) Baltimore 10. Cay, Town of Location (Day Name (Free response), yes yes yes yes yes yes yes yes yes yes		1 - For State Registrar			ertificate of	Death	Re	g. Nõ.	U I	0 7 5 0
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19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Co. Beth Guizzardi/cousin 9200 Stone Spring Lane Pasadena, MD 21122 20b. Method of Disposition 20b. Place of Disposition (Number) 20b. Committed	S		2		recruiter	18 Mother's Nam				busines
Detail Guild Detail De	To Be	Daniel Callahan				Audrey	Moore			
Sequentially list conditions are condition resulting in death Last	une.									Code)
23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	è	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Ob. Place of Di	sposition (Name of					wn, State
23a Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	any injury						655 W. 1	Baltimo	ore S	treet
Physician Medical Examiner Immediate Cause (Final disease or conditions resulting in death) Due to (or as a consequence of):		23a. Part 1. Enter the disease or complic	eations that caused the				or recoverations arres			Annrovimate
Second contribution Control control contribution Control contr		SHOCK, OF HEART VAILURE. LIST ONly On	e cause on each line.	oodiii. Do not	orner the mode of dy	ing, such as cardiac	or respiratory arres	51,		Approximate Interval Betwee Onset and Dea
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inflated events resulting in dealth) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inflated events resulting in dealth) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inflated events resulting in dealth) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inflated events resulting in dealth) Last Sequentially list conditions. Due to (or as a consequence of): Chronic Alcoholism Chronic Alcoholism		disease or condition resulting in death)								
Due to (or as a consequence of): Atrophy of Liver Due to (or as a consequence of): Atrophy of Liver Due to (or as a consequence of): Chronic Alcoholism IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ner	O D D D D D D D D D D D D D D D D D D D			ties					
Due to (or as a consequence of): Chronic Alcoholism	ne ne	if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):						
Chronic Alcoholism	Kam	triat instituted events								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Date of delivery Month		L _d .								
4 Pregnant at time of death 5 Other (specify) 9 Unknown 9	ian/Me	23b. Was decedent pregnant 23	1 Live birth 2 🗌	Fetal death		у		1		ry Day Yea
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	hysic			of death	5 Other (specify)					Ju,
Hypothyroidism, osteoporosis, psychogenic polydipsia 1 Yes 2 No 3 Probab	0 1 - 1	Part II. Other significant conditions cont	ributing to death but no	t resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contr	ibute to the	e cause of deal
24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 14 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 28d. Date of Injury (Month, Day Year) 28d. Date of Injury Nork? 28d. Location (Street and Number or Rural R		Hypothyroidism, osteopo	prosis, psycho	genic po	lydipsia					, (
25. Was case referred to medical examiner? 1	omp						autopsy	ed? q	rior to con eath?	npletion of caus
1 2 No	Be (examiner?				26. Place of Deat			7	
28a. Date of Injury Section Column	-	100 163 2 100	1 X Monpatient		IIII 3 DOA	4 Nursing no)
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Fig. 1) 28f. Location (Street and Number or Rural Fig. 2) 28f. Location (Street and Number or Rural Fig. 2) 28f. Location (Street and Number or Rural Fig. 2)	cation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	28b. Time Injur			28d. Describe hov	v injury occurr	ed	
	Certifi	determined	28e. Place of Injury - building, etc. (S)	At home, farm, pecify)	street, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number
29a. Certifier (Check only 2) 29a. C	-	(Check only 2 Neducal Cxamin	er: On the basis of exar	knowledge, de mination and/or	eath occurred at the trainvestigation, in my	me, date and place, opinion, death occurr	and due to the cau red at the time, dat	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)
and manner stated. 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Date signed)	W	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed	(Month, L	Day, Year)
30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)		- Careal H	allan	Md	OC	ME	Fe	ebruary	7 3. 2	2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1- For Amend Item#26 per PHY G852 2/21-0filicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februar P Day **Physician** OWANDA ANTOINETTE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jenera T05 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 217-78-9407 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow if of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itama 23a or 28e-1 ahos or other treumatic avant, Ita Madical Experimentment be notified at 1 ☐ Yes 2 🗷 No Completed by Funeral Director BALTIHORE IKESVILL 10e, Street and Number 10g. Citizen of What Country? DEBILEN CIRCLE 4622 45A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, • Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 22No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STV415T 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other treumatic as SDES. MAMES ဂ္ MONICA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALISTOWN MD. 21133 (MOTHER) O. BOX MONICA PINKET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State WESTERN STAR CEME. 02-18-06 CATONSVILLE MARNIAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN TR. FUNERAL HOME
JOSEPH H. BROWN TR. FUNERAL HOME FULTON AVE, BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affect, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Due to (or s a c nsequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Puneral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burian-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No 1 Yes Director; After this certific d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Ves 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To ursing Home 5 Residence 6 Other (Specify) 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of rexamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 1/2001 ST HELENA AVE BALTIMORE MD.

Month, Day, Year)

EB 2 1 2006

30. Name and address of person who completed cause of death tem 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 2 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- For the Registramend Item #20b Per FH G852 2/27/19/6/2019 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** , 20AM 2006 AMUE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RITCHIE HOSPICE JOSEPH
5. Social Security Number Months | Dave | Hunder 24 Hrs. | 8, Date of 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JUNE 8; Birthplace (State or Foreign Country) **Funeral** 12M 2 F 9 Months Days Hours Min. 466-64-3843 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "neturel", or Items 23e or 28e-f ehow traumatic event, the Madical Examinar miss be notified at 10d. Inside City Limits Director 1 XYes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 82 STREET USA, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", any injury or other traumatic event, the Mudical Exagnes. 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (นพหมอ พม) (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) I HIGRADE FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CROWDER ဂ 00SEVEL1 SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KOSETTA HALL SISTER BALTO, MD QUARE 2/225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 3/01986 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD. 22. Name and Address of Facility BROWNUR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N N. FULTON AVE., BALTO, MD 21217 23a. Part1, Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory rrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician ancreati months C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š icete hes been sig r, page 2 should b 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: this certificate Vital 1 Yes 20 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6. Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1. Natural 5 Pending within 24 hours efter death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature and title of certifier 10 29c. License number 29d. Date signed (Month, Day, Year) D24170

State Registrar

31. Date filed (Month, Day, Year) FEB 2 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richey Hospice 838 N . Eutaw St 32. Registrar's Signature

February 20,2006

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:00P elemary 19 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TIMORE 130 N SECOURS HOSPITAL BAL If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Days 1□M 2♥F Months Hours Min 59 -40 Director 6 North Usual Residence of Decedent filed within 72 hours after death with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director Maryland
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ៰ 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced a naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Heelth and Mental Hygie If itam 27 is marked other t or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Val 2 19a. Informant's Name/Relationship (Type, Print) | Q | Cun 1 on) 19b. Mailing Address (Street and Number or Rural Route, Number, City-or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date City or Town, State 20a. Method of Disposition 20c. Location -0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <u>≒</u> ö Depertment of Importent: If any injury or once. 2006 * 4 Donation 5 □ Other (Specify) Ceme 21. Name and Address of Funeral Service Licenses Inter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO MYOPA Physician SEVERE disease or condition resulting in death) /Medical Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit RATION The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊕Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy rmed? 2 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 1No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 TYes 2 Accident investigation Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hours e State

KOSITA 31. Date filed (Month, Day, Year) FEB 2 1 2006

29b. Signature and title of certifier

0 30. Name and address of person



and manner stated.

cause

(Item 23a) (Type, Print)

29c. License number

00030355

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		artment of F			jiene	6 N	1.968
	Physici	an	1. Decedent's Name (First, Middle, Last)	0117				2. Date of Dea Month	th Day	rear 3.	Time of Death
}	/Medic Examir		4a. Facility Name (If not institution, give s NONTHUEST H	treet and number)	Jan	4b. City, Town, o	Location of De	TSPRU ath	4c. County of	Death Times	Am
	Funeral Director		5. Social Security Number 212-30-5064 Usual Residence of Decedent	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		Year) /1913	9. Birthplace Country) MARYI	(State or Foreign
	e Maryland la-f ehow	ctor	10a. State 10b. County MD N/A	10c. Cil	y, Town or Lo	cation IMORE CI	ΙΤΥ				Inside City Limits
	3a or 26	I Dire	10e. Street and Number 3327 BRIGHTON	STREET		10f. Zip Code 21 21	16	1	log. Citizen of Wh	at Country?	
980	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "naturel", or items 23a or 28s-1 show event, the Medical Exerction must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		f Yes, specify Cubi	an, Mexican, Pue	Specify Yes or No- orto Rican, etc.)	14. Race	- American In White, etc. BLAC	
21215-0036	d within 72 ho piene. r then "natur Ine Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8 TH		(Give	dent's Usual Occup kind of work done DO NOT use retired IEMAKER	during most of w	orking	16b. Kind of Busin		у
	should be filed nd Mental Hygin i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) HENRY BROWN				MARG		ENT		
Mar	0 6 6		19a. Informant's Name/Relationship (Type GEORGE CARTER /	son SON				Rural Route Number			^{3e)} 21216
Baltimore, Maryland	Pages 1 and 2 ment of Heelth ant: If item 27 ury or other tru		20a. Method of Disposition XXBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		emetery, crer	sition (Name of natory or other place) N CEM.		Date :	20c. Location - C	-	State MD
Balt	permit. Page Department of Importent: If in eny injury or		21. Signature of Warra Service License	of A. Are		Name and Addre	1.	OWELL F			21207 MORE, MD
i.	Physician /Medical Examiner		23a. Part Enter the disease, or complic shock or hear failure. List only on Immediate Cause (Final disease of condition resulting in death)	e cause on each line.	Do not ent					App	proximate erval Between set and Death
8760,	ate be executed thy sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t							
P.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date Monti		Year
	w requires thet the de been signed by the a should be detached f	ğ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		bacco use contrib es 2□No 3	oute to the ca	
Division of Vital Records,	: The law recate has been pege 2 sho	Completed	Dettydnatis	Ŝu				24a. Was a autops perform	med? pri	ere autopsy for to complet ath?	findings available tion of cause of
Vita	sician: Th certificate rector, peg	Be	25. Was case referred to medical examiner?	ospital:		. all Doa Oth	Ar-	eath Check only or			
on of	nding Phys th. : After this s funeral di	ition: To	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 🗆 Nursing	Home 5 ☐ Reside	ence 6 Other		
Divisi	To the Hospital or Attending Physician: within 24 hours effer deeth. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, str y)	eet, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural Rou	ute Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	edicai	one) 2 Medical Examin	ician: To the best of my known the control of the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and manr late and place, an	ner as stated d due to the	cause(s)
)	To To con	Σ	29b. Signature and title of gertifier	and bu	d	29c. Licens			9d. Date signed (-	
	3		30. Name and address of per on who	eted cause of death (Item	п 23a) (Туре,	Print)	Nen	74W257	408/11	et L	7, 2066 CENZEN
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2. 1. 200	32/Registrar's Signa	iture	red s	7.71.00		/		-11.33

			1 - For State Registrar	State of Ma	arylan		artment of rtificate of	Health and f Death	Mental Hy	giene Reg. No.	06	04969
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	eath Day	Year	3. Time of Death
	/Media	cal	Donald J. Creig				4 0: -	3, 3, 3, 3, 1, 2, 2, 3	02-	16-	06	7:50 am
	Examin	er	4a. Facility Name (If not institution, give si	./	1. /	40		or Location of Deat	th		unty of Death	
	Cunaval		Franklin Square h. 5. Social Security Number 6. Sex	05p, ta/ (last birthday)	Kose If Under 1 Yea	If Under 24 Hrs	8. Date of Bi	th Ba	_//7 M	nplace (State or Foreign
	Funeral Director			M OFF	60	Yrs.	Months Day	s Hours Min	8. Date of Bi (Month, Date Jan. 25	1946	Cali	untry) fornia
	pc ,		Usuaf Residence of Decedent		10.00							
	anylar how	2	10a. State 10b. County			ty, Town or Lo						10d. fnside City Limits 1 ☐ Yes 2 No
	r 28a-f ehow	ectc	Maryland Baltimore			Catons	ville 10f. Zip Code			10a Citizan	of lath at Ca	
	death with the Maryland me 23s or 28s-f show r must be notified at	급						1228			of What Cou	antry?
>	Jeath The 23	era	2 Monroe Field Coun	2. Was Decedent I	Ever in U	.S. 13.		f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No	o- 14.	Race - Amer	
29	or Itan	Fur	1 ☐ Never Married 2(X Married	Armed Forces? 1 ☐ Yes 2 ☒ N	No	1			to Rican, etc.)		^{Black,} White _{ecify:} Whi	
200	ral', c	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ N	o Specify:		Spe	∍cify: WIII	
<u>\rac{1}{2}</u>	natu	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade			/Give	dent's Usual Occi kind of work don	e during most of wa	rking	16b. Kind o	of Business/I	ndustry
1-12	within ane. then	m	Elementary/Secondary (0-12)	Colfege (1-4or 5	5+)		DO NOT use retin	,		Educa	tion	
22	filed within Hygiene. other ther there ant, it a M	ပိ	17. Father's Name (First, Middle, Last)	JT		Onemi	istry III		me (First, Middle			
ta/	ba da b	To Be	William Henry Cre	ighton				Hele	n Karin	Norber	g	
Maryl	s 1 and 2 should be f Heelth and Mental frem 27 le marked c	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Maili	ing Address (Stree	et and Number or R	urai Route Numb	er, City or To	wn, State, Z	ip Code)
0.2	5 € Z		Arlene Creighton	Wife				eld Court	Catons	ville,	Mary	land 21228
$\sigma_{\mathcal{C}}$	es 1 a/of Hee		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	amoval from State	20b. F	Place of Disponentery, cre	osition (Name of matory or other p	lace)	Date		on - City or 1	
altimore,	ment tant:		4 □ Donation 5 □ Other (Specify)		Me		ematory		2000		-	, Maryland
Bail	permit. Pages 1 Depertment of H Important: If Ite eny Injury or ott		21. Signature of Euneral Service License	X	11	2	Funera1	ress of Facility St Home of	Catonsvi	11e, I	nc.	
	403.44		23a. Part1. Enter the disease, or complic	SH	Jan door	th Do not on	1630 Edi	mondson A	venue; (Catonsy	ille,	MD 21228 Approximate
			shock, or heart failure. List only on Immediate Cause (Finaf	e cause on each fir	ne.	in. Do not en	ter the mode of d	ying, such as cardia	c or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	2ex	10						
	Examiner		1	Carc	100	mat	nsic					
		ner	Sequentiaffy list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (pres	a gunseu	juence of):	-510					
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	be executed slcien and burial-transit		resulting in cealing cast	Due to (or as	a consec	quence of):						
87	cate be	dicai	d.									
9 X	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						23d.	Date of defr	verv
ĕ	death e atte	iciai	in the past 12 months?	1□Live birth 4□Pregnant at			□Ectopic pregnan □ Other (specify)				Month	Day Year
P.O. Box	at the de by the a	hys	9 Unknown	9□ Unknown								
s,	as tha	by P	Part II. Other significant conditions conf	tributing to death b	ut not res	sulting in the u	underlying cause o	given in Part f.	23e. Did			the cause of death?
ord	w require been sig should b								10	Yes 200 N	o 3∏Pro	obabfy 4 Unknown
ec	law hasb	Completed							24a. Was	DSV	prior to c	topsy findings available completion of cause of
<u> </u>	: The lav								120 Yes	ormed? 2□ No	death?	2 🗆 No
Zit.	siclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:)ther	ath (Check only			
o to	Phys or this oral di	۲: To	1 ☐ Yes 2 🐼 No	1 X Inpatie	rv	28b. Time o	III SU DON	4 🗀 (Nursing)	Home 5 Res			afy)
<u>.o</u>	nding f ath. r: After e funer	atio.	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury		lork? ∐Yes 2∐No		. ,		
Division of Vital Records,	Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At h	ome, farm, st	reet, factory, offic	20	28f. Location	(Street and N.	<i>umber or R</i> u	iral Route Number,
Ö	Ital or is after al Dia led in	Cer										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier Certifying Phys	er: On the basis of	f examina	owledge, dear ation and/or in	th occurred at the	time, date and plac y opinion, death occ	e, and due to the urred at the time	cause(s) and	d manner as	stated. to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner sta	ated.	1	29c Lice	vnse number		Jod Date si	anned (Month	h Doy Yaar)
	£.₹₽.8		1 (1h Ch	till. I.	11	ma	1	24.751		Fall	-16	200%
	1		30. Name and address of person who con	mpleted days of d	leath (fter	m 23a) (Tune	Print)	,000				
l	2		Dr. William C. W	aterfield	190	00 Fra	nklin So	24356 quare Di	rive Ba	Himera	. Md.	21237
		ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Sign	ature	3 • 40		· · · ·	, , , , , ,	p	
	Regist	rar	FEB 2 1 2006	A State of the same	e A							

Certificate of Death

Reg. No.

Year

2006

USA

Specify:

14. Race - American Indian, Black, White, etc.

White

10:30

10d. Inside City Limits

Approximate Interval Between Onset and Death

2 DAYS

20 YEARS

23d. Date of delivery

1 Tyes

2435 WEST BELVEDERE AVE. BALTIMURE, MD 21215

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

1 Yes XXNo

Birthplace (State or Foreign Country)

Maryland

AM

2. Date of Death

PETER W CHO M.D.

1 2006

31. Date filed (Month, Day, Year)

For State Registrar

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

Registrar

SINAI HOSPITAL

32. Registrar's Signature

			1 - State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			nd Me		ene g. No.	06	049	71
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Beverly	Jean	Ca	in					2 Date of Death Feb. 16		6 Year		of Death 35a _M
	Examir		4a. Facility Name (If not institution, give s Holy Cross Ho					Town, or l					ty of Death	ery	
	Funeral Director		5. Social Security Number 6. Sex 356-22-9335	7. Age	9 (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day, 7 / 28 / 1	Year) 1928	Cour	olace (State ntry) lino:	or Foreign
	Maryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ery		y. Town or Lo Kensi		n					1	I0d. Inside	City Limits
	3a or 28e-	Funeral Director	10e. Street and Number 3310 Oberon Sta	reet			10f. Zip		895		10	g. Citizen o		ntry?	
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "naturel; or Iteme 23e or 28e-f ehow imatic event, the Medical Exam or marked.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates:		'	Was Deced f Yes, spec	ofy Cuban	panic Orig , Mexican, Specify:	in? (Spec Puerto R	offy Yes or No- lican, etc.)		ace - Americ ack, White, ify:		
21215-0036	filed within 72 ho Hygiene. Ither than "nature ent, the Medical	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5	+)	life. i	dent's Usua kind of wo DO NOT us forc	rk done du se retired)	ring most		g 1	6b. Kind of	Business/In	•	
Maryland	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Arthur Bryan C								(First, Middle, M Laverne				
	nd 2:		19a. Informant's Name/Relationship (Ty, Mary Dugan/Sis		-T	606	Pol	k St	reet	Su	Route Number, llivan	, Ill	inoi	s 61	951
altimore,	permit. Pages 1 al Department of Hea Important: if Item eny injury or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			lace of Dispo emetery, crer ibert	у Се	mete	ry 2		/06	oc. Location Sulli	van,	Illi	
Bal	Departiment imported in ported k	21. Signature Funeral Service License	Dr.		9	241	Colu	mbia	Bl	FUNER	ver S	ERVIC Sprin	g,Md	<u> 20910</u>	
ji.	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Mesent Due to (or as	ie. <u>Ceri</u> a consegi	c emb	olic	isc	hemi	ia				Approxim Interval B Onset and 36	etween Death hrs
58760,	icate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	S OI	aor	ta a	ina	mesent	eric	VE 25	eis	1371
P.O. Box 68	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3□	Ectopic pr Other (sp						Date of deliver	ery Day	Year
	w requires that the de- been signed by the e should be detached t	by	Part II. Other significant conditions con	tributing to death bu	ut not resu	ulting in the u	nderlying c	ause giver	in Part I.		23e. Did toba	acco use co	ntribute to t		f death?]Unknown
Division of Vital Records,	The ste h	Completed									24a. Was an autopsy perform		were auto prior to co death? 1 \(\text{Yes}	mpletion of	s available cause of
=======================================	ician Sertiff ector	a	25. Was case referred to medical examiner?	ospital:				1		of Death	(Check only one)			
<u></u>	Physician: r this certifice ral director, I	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Impatie		ER/Outpatier			4 LI Nur		e 5 Resider			(y)	
Sion	g = e	Certification:	21. Maturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	М		es 2 N	lo	8d. Describe hov				
N N	i Ditt		4 Homicide determined	28e. Place of Injubulding, etc	. (Specify	<i>(</i>)					8f. Location (Stre City or Town,	State)			Imber,
	To the Hoepital within 24 hours at the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinate of Certifying Physical Check only 1 (Check only 1 one)	ner On the basis of and manner sta	examinat	wledge, death tion and/or in	vestigation.	, in my opi	nion, deat	l place, ai	d at the time, da	te and place	and due to	the cause	
•	7 ½ Z Ø		Jan 1)/2				-	D2/	153	·			.16,2	2006	
F			30. Name and address of person who co	SEN	1117	23a) (Type,	Print)	AHTS	HILL	5 fo	16 S	lune	Parmy	, AD	zenej
	Sta	te	FFR 2 1 2006	32. Registra	ar a aigna	tule and	8 1								

		1 - For State Registrar	State of Maryla	•		nt of He te of D			giene Reg. No.	006	04972
100		1. Decedent's Name (First, Middle, Last						2. Date of Dea	ath Day	Year	3. Time of Death
Physici /Medic		DARRYLIC	HANDLE	ER				FEB	13	5 200	6 10:21P
Examir		4a. Facility Name (If not institution, give			4b. City	Town, or Lo	ocation of Death		4c. (County of Deal	
- S.	200		al Cente				ORE,	MD			
Funeral		5. Social Security Number 6. Se	7. Age (In yi	s. last birthday Yrs.	Months		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Bird	hplace (State or Foreig puntry)
Director		212-80-6945 Usual Residence of Decedent	٥.) 1,3.				4-16-	1972		Md
yland wow		10a. State 10b. County	10c.	City, Town or L	ocation.						10d. Inside City Limits
Mar.	ţō	Md N	/A :	Balto							1 ∑Yes 2 ☐ No
th the	lrec	10e. Street and Number			10f. Zi	Code			10g. Citiz	en of What Co	ountry?
23a c	ai D	218 N. Charles Str	eet			2120	01		U	S A	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Department of Heatly and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show amy injury or other traumatic event. The Medical Examinar must be inclined at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Dece If Yes, spe 1 Yes	cify Cuban,	anic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, Whit Specify: B	
72 hc	etec	15. Decedent's Edu (Specify only highest grad		(Give	e kind of w	al Occupation	on ring most of wor	rkına	16b. Kir	d of Business	/Industry
ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	ise retired)			Aţr	ium/So	uthern
led w tygie her ti		12th grade 17. Father's Name (First, Middle, Last)	N/A	Le	asing	Agen		ne (First, Middle,		agemen	t Co.
ntal H	Be	Roy Chandler				1		her Com		,	
d Me mark mark	2	19a. Informant's Name/Relationship (T	ne Print)	19h Mail	ling Address	s (Street and		ıral Route Numbe			Zin Code)
d 2 s th an 7 is r							n Stree			21216	zip Code)
1 an Heal Heal Heal		Doreather Chandl 20a. Method of Disposition		. Place of Disp	osition (Na	me of	n Stree	Date		cation - City or	Town, State
ages ont of t: If ii		1 🗓 Burial 2 Cremation 3 🗆		t Carme			2/20	/2006		to, Md	
rmit. Pages 1 ac spartment of Hea portant: If item y injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens				nd Address					
en y pen		1 2/108,08	lmond			4300	Pi	larch F/I h Avenue			21215
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the dene cause on each line.			de of dying,	such as cardia		rrest,		Approximate Interval Between
icate be executed by sicien and by sicien and sithe burial-fransit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	IUNE	DE	FICIE	JCY SY	NDI	ROME	YEARS
entific ling p	1 0	IF FEMALE:									
thet the death certificated by the attending of	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic _I □ Other (s				2	3d. Date of de Month	livery Day Year
es thet igned by be deta	by Pł	Part II. Other significant conditions co	ntributing to death but not	esulting in the	un derlying	cause given	in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
sician: The law requires to certificate hes been signe rector, page 2 should be								10	Yes 2[No 3∏P	robably 4 Onknow
The law requires the hes been sign bage 2 should be	Completed							24a. Was		24b. Were a	utopsy findings availabl
The lav	mo o								rmed?	death?	comptetion of cause of 2 □ No
ician: Th certificate rector, pag	0	25. Was case referred to medical					P6. Place of De	1 ☐ Yes ath (Check only o	No No	1 105	2 LIN0
	To B	examiner? Yes 2 No	lospital: Inpatient 2	☐ ER/Outpatie	ent 3 🗆 D	Other		lome 5 ☐ Resi		i∏Other (Spe	icifv)
ding Physician: n. After this certific tuneral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time		28c. Injury a Work?	it	28d. Describe			,,
Attending r death.	atlo	Natural 5 Pending 2 Accident investigation	(Mona, buy rous	injury	М		s 2 No				
in the second	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		treet, facto	ry, office		28f. Location (City or To			ural Route Number,
Hospitel or 24 hours efte Funerel Dir etely tilled in	edicai	(Check only 2 Medical Exam	sician: To the best of my iner: On the basis of exam	nowledge, dea	nvestigatio	at the time	data and plane tion, death occi	and due to the urred at the time.	date and	and manner a	s stated a to the cause(s)
To the P within 2 To the E complete	Med	0/10)	and manner stated.								
₽ ₹ ₽ 8	-	29b. Signature and title of certifier				c. License r				e signed (Moni	
		Michalla	2.00	10	I	000	33	26	LE	B 15	2006
		30. Name and address of person who o		tem 23a) (Type	Print)	. 1.1-		(- ~ 5	20	NORE MD
South at the contract of the c	ate	31. Date filed (Month, Day, Year)	OLAKIA. N 32. Registrar's Si	nature A	IEKC	ME	DICAL	CENTE	=14, 1	> L L I (N	VOICE INITZ
	ate rar	FFR 2 1 201	6 Person	S. A.	Bayes &						

Earnest Colbert Unpend item# 23a, 27, 28a-f, pen/E, 053, 3/2//00 III

Amend item#PII, 27, 28d, pen/E, 053, 3/2//00 III

Amend item#PII, 27, 28d, pen/E, 053, 3/2//00 III

Amend item#PII, 27, 28d, pen/E, 053, 3/2//00 III UNK 06-00546 NJM 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Earnest H Colbert 22 2006 /Medical January 1550 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3607 Everett Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Apr 2, Birthplace (State or Foreign Country) Months Days Hours Year) 1944 1)SM 2 F 61 Yrs. Director 218-42-6166 Apr Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location ehow 10d. Inside City Limits r than "naturel", or items 23a or 28a-f ehov the Medical Example must be notified at ō MD Baltimore 1 Yes 2 □ No Direct tha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? daath with 3607 Everett Street 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours aftar Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Specify: Black Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filad within Food Service other than Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pagas 1 and 2 should be filad w Dapartmant of Haatih and Mantal Hygiar Importent: If item 27 is marked other th eny filury or other traumatic event, Ina pace. Cook 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Earnest Colbert Pearl Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone Colbert / Son 7879 Tall Pines Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Feb 6 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State alas Crematory MD EdgeWater 4 Donation 5 Other (Specify) 2006 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Miller's Metropolitan Chapel 1922 Forest Drive Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic cardiovascular disease complicated by hypothermia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law raquiras that the daath certificata ba axecutad been signad by tha attanding physician and should ba datached for usa as tha burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Torso and extremity injuries Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Yes 2 □ No cartificata has autonsy performed? Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Theck only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 65 Other (Specify) Scene 2 Yes 2 No Aftar thi 27. Manner of Death M 28c, Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred unk Vitin 24 hours after deam.

To the Funeral Director: At 1 Natural 5 Pending 2 X Accident investigation М 1 ☐ Yes 2 X No Fnd 1/22/2006 unk exposure to cold environment 6 X Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3607 Everett St. 4 Homicide yard Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January, 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID LUCKE 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State 32. Degistrar's Signature

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year GERALDINE MARIE COSTELLO CARLIN 1:45 A. February 18, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 21, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 93 Director 213-46-4732 1912 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "naturei', or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🛱 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Metfield Road death 21286 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home Pages 1 end 2 should be filed vent of Heelth and Mental Hygient: If Item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Costello Goldie G. Avev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent F. Carlin, Jr. 1104 Metfield Road (son) Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Depertment o importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 2-20-06 Baltimore, Maryland 21. Signature of Funeral Service Licensee Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland Seored Ferrage 6500 York Road Baltimore,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) ed by the detached Ö 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Únknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wasan autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death [Check only one] Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 05 PICL ၉ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending M 1 Tes 2 No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funstei 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and Me of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

Chruary 18,2006

Dulaney Valley

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahmood

FEB 2 1 2006

32. Refistrar's Signature

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31. Date filed (Month, Day) Year)

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	D		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	70 C	Æ.	Genesis Heritage Center	Dundalk		Baltimore	
82	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign ltry)
- **	Director		279-54-5527 52 Yrs		Mar 5, 19	Penns	sylvania
	ehow		10a. State 10b. County 10c. City, Town of	r Location		1	0d. Inside City Limits
	a-f el	to	MD Baltimore Balt	imore		a de Malana	1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	itry?
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36	filed within 72 hours afler death with the Maryland Hygiene. other then "natural", or terme 23a or 28a-f ehow ent. The Madical Examination multiplied at	y Funerai	1 Never Married 2 Married 1 Yes 2 No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2∑ No Specify: 	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: whi	etc.
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פ	Hyg other	BeC	17. Father's Name (First, Middle, Last)	nstress 18. Mother's Nam	ne (First, Middle, Mai	clothing den Sumame)	
an	lenfa berked ked	To B	Lawrence Virgil Drury	Sally S	yne Sayloı	r	
Maryland	should by man			ailing Address (Street and Number or Ru			Code)
Σ	and 2 alth a 27 I		Jayla Watje/daughter 41	S. East Avenue Ba	ltimore, N	4D 21224	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Menfal Hygiens. Integrant: if Item 27 is marked other then "natural", or Iteme 23e or 28a-1 show propriant: if Item 27 is marked other then "natural", or Iteme 23e or 28a-1 show empty injury or other treumatic event. It a Marical Examinational Canadiged at Appres.			sposition (Name of crematory or other place)	Date 200	c. Location - City or To	wn, State
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Division of	l or Att affer d Direct d in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura Itate)	l Route Number,
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			30. Neme and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		11916	
			avinda a Tule 2 Mix	Kel- Mara Dis	star 1	Mr) 21	22
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- A := -	Col - 1	· / /	
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			1 - For State Registrar	State of M	arylar		artmen <i>tificat</i>			ınd M	,	giene	106	01.076
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۳	Funeral		5. Social Security Number 6. Se 220-05-0451	X 7. Ag	ge (In yrs. 85	last birthday) Yrs.	Months Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir June 8	th ly, Year)	9. Birth	nplace (State or Foreign untry) Cally
l.	Director		Usual Residence of Decedent		- 05						oune o	, 1920	, 11	Lary
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
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	ems ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Vas Dece				ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
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<u>a</u>	Aental Aental rked o	To B	Nicholas	DiMenna						An	na Cuc	chio		
Maryland	and N		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address	(Street a	and Numbe	r or Rura	I Route Numbe	er, City or To	own, State, Zi	ip Code)
	and 2		Mr. John DiMenna/S	on		914 W			Rd.	Bal	timore,	, Mary	land 2	21212
ore	of Ho		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State		Place of Dispo cemetery, cren	sition (Nar. natory or o	ne of ther place	9)		Date	20c. Local	tion - City or T	fown, State
altimore,	. Pag tment tent: jury d		* 4 ☐ Donation 5 💆 Other (Specify,	Entomb	Dul						20/06		-	•
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental hygiene. Importent: If item 27 is marked other then "neturel", or items 23s or 28e-f show empty injury or other treumetic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Licens	1 Rue	8/		. Name an 050 Y				k Towson, Ma			lome, Inc. 04
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ications that cause ne cause on each li	the deat	h. Do not ente	er the mod	e of dying	g, such as o	cardiac c	or respiratory ar	rrest,		Approximate Interval Between
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ec	a law nas b e 2 st	Completed									24a. Was	sy	prior to co	opsy findings available ompletion of cause of
Vital Records,	: The lay cate has page 2											rmed? 2- No	death? 1 ☐ Yes	2 No
Zi tr	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only o	ne)		
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	To the To the Comp	¥	29b. Signature and title of certifier				290	License	number			29d. Date si	igned (Month,	Day, Year)
}			Sno	NND				DOC	153	158		FEB	1650	2006
1	21/7		30. Name and address of person who co	ompleted cause of d			Print)							
10	7		Shallynnac			1650	5 A	M	10 C	o a	010	, 50,	7611	2045
	Sta Registr	4 2	FEB 2 1 2006	32. Registr	ars Signa	iure					60	CUN	15113	er es

Amend item#10f,13, perfH, 252,2/28/06 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 16, 2006 11:55 A M Robert David Dallen, Sr. February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 21, 9. Birthplace (State or Foreign Country) New York **Funeral** Days Hours 12XM 2□ F 80 Yrs 056-24-7361 May Director 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 11929 Ledgerock Court 20855 Itsms 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ NoWWII

If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ No Yes 2 No White þ Specify: 3 Widowed 4 Divorced "natursl", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) Account Executive IBM .. Pages 1 and 2 should be filed w tment of Health and Mental Hygler tant: If Itam 27 is marked other th jury or other treumatic event, Ill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myron Francis Dallen, Sr. Julia Havas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel Fox Dallen/Wife 11929 Ledgerock Court, Potomac, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If Its any Injury or ot once. Potomac United Methodist Church Cemetery February 20, 1 Burial 2 ☐ Cremation 3 ☐ Removat from State 4 Donation 5 Other (Specify) 2006 Potomac, Maryland Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funetal Service Licensed ARIE MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Physician memeliale /Medical resulting in death) Due to (or as a consequence of) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ettending physiclen and forjuse as the burial-transit or Attending Physician: The law requires that the death certificate be executed heline 18 un. 11SS AM resulting in death) Last Due to (or as a cons-P.O. Box 68760 Physician/Medical 90 IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 9 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 6 Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Concenerna 1 ☐ Yes bex + 2 Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 1 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 2 Accident Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No in by the Director: 6 Could not be 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by determined 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of contifier. 29d. Date signed (Month, Day, Year) un death (Item 23a) (Type, Print) address of person who completed cause of 201 м.Ф., J. Blaine Fitzgerald, 8218 Wisconsin Avenue, Suite 408, Bethesda, MD 20814 31. Date filed (Mogth, Day, Year) 32. Registrar's Signature State Registrar 2006

		•	1 - For Stete Registrar	State of Maryland	-	artment of H tificate of L			giene Reg. No.	16	1497	8
			1. Decedent's Name (First, Middle, Last)		-			2. Date of Dea Month	ith Day	Yeer	3. Time of	Death
	Physicia /Medic		C1a	rence James	Duke			Februar	y 15,	2006	5:55	AM
130	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	n	4c. Cou	nty of Death		
Ţ		4	Holy Cross Hospit				Spring			ontgom		
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	v Year)	Cour	lace (State or ntry)	-
L	Director		280-24-5243 ¹☒ Usual Residence of Decedent	M 2LIF 77	Yrs.			May 12	, 1928	Penns	sylvan:	ia
	and and		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside Cit	y Limits
	Mary f sho	ō	Maryland Montgome	rv C	hevy C	hase					1 🗆 Yes	2 📉 No
	288 1001	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen	of What Cour	ntry?	
	38 o		3507 Dunlop Stree	t		20815			Unitod	l State	20	
	deatl ms 2	Funerai		2. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S			Race - Americ	an Indian,	
o	after or Ite		1 ☐ Never Married 2 📉 Married	Amed Forces? 1 X Yes 2 □ No If Yes, Give WWI	-	r res, specify Cubai 1 □ Yes 2 No	Specify:	o nican, etc.)		Black, White,		
2-003a	ours urel',	d by	3 Widowed 4 Divorced	Year or Dates:		103 242140	Specify.		Зре	city: Wh	ite	
ก็	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of	fu <i>rina m</i> ost of wor	rking	16b. Kind o	f Business/In	dustry	
N	within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, Bician)		Privat	e Prac	otica	
N	iled v Hygie ther i		17. Father's Name (First, Middle, Last)	5+	11190	, readi	18. Mother's Nar	ne (First, Middle,			LICE	
and	d be intal	Be c	Clarence Duke					Moody				
<u></u>	2 should be filed within 72 hours after death with the Maryland and Mantel Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show eumatic event, the Medical Exert in writings the notified at	^L	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a			or, City or To	wn, State, Zip	Code)	
<u> </u>	od 2 sulth ar 27 ls		Gloria Eng Duke/Wi		3507	Dunlop St	treet, C	hevy Cha	se. Ma	rvland	1 20815	5
ā,	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other treumatic		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place		Date		on - City or To		
Ê	Page ento nt: If ry or		1 🖾 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	amoval from State		Le1's Cemet			Potoma	ac. Ma	ryland	
Baitimor	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tre once.		21. Signature of Funeral Service Ligense			Name and Address bert A. Pum		and the second second second second				
'n	g a E a		Ungelette Ban	M0130	5 75	57 Wisconsi	n Avenue,	Bethesda,	Marylar	nd 20814	-3501	Inc.
			23a. Part1. Enter the disease, or complic shock, of heart failure. List only one	ations that caused the death	n. Do not ent	er the mode of dying	g, such as cardiad	or respiratory ar	rest.		Approximate Interval Bety	ween
	Pnysician		Immediate Cause (Final disease or condition	Crytogenic							Onset and E	Death
¥	/Medical		resulting in death)	Due to (or as a consequ		IIC MCCIV	Hepati	L 1.0				
	Examiner	,	Sequentially list conditions. b.									
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	uence of):							
	and I-tran	хаш	that initiated events resulting in death) Last	Due to (or as a consequ	uance of):							
8/60,	the death certificate be executed y the attending physician and Iched for use as the buriat-transit	icalE		2 23 10 (01 23 2 20110041								
ğ	icate phys s the	TO	d.									
×	eath certific attending p	lan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ncy				23d.	Date of delive	erv	
X Q	death atte	O	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)				Month		ear/
j.	at the de by the a stached	Physi	9 Unknown	9□ Unknown				,				
ران ح	The law requires that ite has been signed b page 2 should be deta	by P	Part II. Other significant conditions cont	ributing to death but not rese	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use o	contribute to t	he cause of d	eath?
ğ	aquire en siç ould b							10	res 2⊠No	o 3 🗆 Prot	oably 4 □U	Inknown
Hecords,	law re as be 2 sho	Completed						24a. Was			psy findings a	
		Som						perfo 1 ☐ Yes	rmed? 2 X No	death? 1 Yes		
Vitai	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o				
o lo	Physician: this certific ral director,	2	1 ☐ Yes 2 🙀 No	43.	ER/Outpatier		4 Indisting i	lome 5 Resid			y)	
	fter fter	ion	27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe I	now injury oc	curred		
SIC	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	One Diese of Joseph At he			Yes 2 □No	29f Location /	Stroot and Ale	umbos os Oue	J Davita Alum	bas
Division	or A after Direction by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	уп е, тапп, str у)	eet, ractory, office		28f. Location (S City or Tox		inder or Hura	ir Houle raum	Der,
	pltel		29a. Certifier 1M Certifying Phys	ician: To the best of my kno	wledne deati	n occurred at the tim	ne date and place	and due to the	causa/s) and	I manner as s	tated	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Examinations)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	pinion, death occu	urred at the time,	date and pla	ce, and due to	o the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1		29c. License	number -		29d. Date sig	gned (Month,	Day, Year)	
			Berard a. Hecomi	en, H.D.			5373		Febru:	ary 16	, 2006	
	110		30. Name and address of person who cor		1 23a) (Type.				777			
10)"		Bernard A. Heckman	1, M.D. 8830	Camer	on Street	, Silver	Spring	, Mary	land 2	0910	
	Sta		31. Date filed (Month, Day, Year) FEB 2 1 2	32. Pagistrar's Signa	ture	1300						
	Registi	rar	1 LU & 1 21	JULI JERRES .	No 19	The state of the s						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** February 13, 2006 7:45 PM M Betty Minor Duffy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Montgomery Potomac 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Il Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Director 85 266-32-0529 December 13, 1920 0klahoma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. . other then "naturel", or fleme 23a or 28e-1 ehow vent, tra Medical Examinat must be notified at 1 ☐ Yes 2√ No Directo Maryland Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5702 Mohican Road 20816 death Funeral <u>United States</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Gallery Owner 4 Art permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked otherly Injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Robert Minor Wrenetta Tanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth LaGrone/ Daughter 2015 Milford Street, Houston, Texas 77098 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 February 15, 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee 4M00335 23a. Part1. Enter the disease, or competcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed anding physicien end use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No is after deau...
rel Director: After this ceru...
is by the funeral director, p? 1X Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0054566 February 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, M.D. 1220A East Joppa Road, Towson, Maryland 21286 31. Date filed (Morlth; Day, Year) 32. Registrar's Signature State Registra

ORIGINAL

			1 - For State Registrar	State of Ma	•	epartment of Certificate		nd Mental Hy	Reg. No.	04980
	Physici		1. Decedent's Name (First, Middle, Last) Tibor Eichenbaum					2. Date of De Month 02		3. Time of Death 04:20p M
	/Medio		4a. Facility Name (If not institution, give s Casey House	treet and number)			wn, or Location o		4c. County of	
4	Funeral Director		297-10-0977	M 2□F 7. Ag	e (In yrs. last birtho	Months D	Year If Under 2 Pays Hours	8. Date of Bi Min. (Month, Date of Bi		9. Birthplace (State or Foreign Country) Hungary
	B Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgo	mery	10c. City, Town o					10d. Inside City Limits ty⊠tYes 2 ☐ No
	with th	Director	10e. Street and Number 5802 Bradley Blvd			10f. Zip Co	20814		10g. Citizen of Wh	nat Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23s or 28s-f show other treumstic avent, the Medical Exeminal must be notified at	by Funeral		2. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		13. Was Deceden If Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	0- 14. Race Black,	American Indian, White, etc. White
Maryland 21215-0036	filed within 72 ho Hygiene. other then "netur ent, the Medicell	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		5+) (C	ecedent's Usual C Bive kind of work of te. DO NOT use i ecutive	done during most	of working	16b. Kind of Bus	
/land	should be filed and Mental Hygia marked other umatic avant, in	To Be C	17. Father's Name (First, Middle, Last) Victor Eichenbaum					r's Name <i>(First, Middle</i> ıla (unknow)
	1 and 2 sho Health and I tem 27 is me other treums		19a. Informant's Name/Relationship (Ty) Leslie Morgan/dug		58	02 Brad1	ey Blvd	r or Rural Route Numb Bethesda M		tate, Zip Code)
Baltimore,	permit. Pages 1: Depertment of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		isposition (Name crematory or othe eake Cre	1	Date 02-21-200		rity or Town, State
Balt	permit. Depertr Importe any inji		21. Signature of Funeral Service License		01358	Rapp F	Address of Facility uneral & st Av Si	y Cremation 1ver Sprin	Service g MD 2091	.0
No.	Physician / Medical Examiner physician and physician into physician and physician sit in the	xaminer	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flag leading to minute the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Advar Due to (or as	a consequence of	n Cancer	n dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and as been be detached for use as the burial-transit	Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	of pregnancy 2 Fetal death t time of death	3 ☐ Ectopic preg 5 ☐ Other (spec	ify)	23e. Did	Mont	of delivery h Day Year
ords,	w requires to been signer should be	eted by						10	Yes 2√∑No	B Probably 4 Unknown
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o	ding Ph n. After th funeral	ation: To Be	eyaminer?	ospital: 1 Inpati 28a. Date of Inju (Month, Da	ent 2 ER/Outp ury 28b. Tin uy Year) Inji		0	28d. Describe		(Specify) Hospice
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, e	jury - At home, farm tc. (Specify)	n, street, factory, o	office		(Street and Number own, State)	r or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dis completely filled in	edicai	(Check only 2 Medical Exemi	ician: To the best ter: On the basis of and manner st	of examination and/	or investigation, in	my opinion, dea	d place, and due to the th occurred at the time	e cause(s) and man , date and place, ar	ner as stated. nd due to the cause(s)
)	To t To t	×	29b. Signature and title of tertifier	\sim	WD		3563	5	29d. Date signed 02-20-2	(Month, Day, Year)
İ	0 1		30. Name and address of person who con Joseph Kaplan 600	Muncast		ype, Print)				
*	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 1 2006	32. Regist	rar's Signature	icië)				

				1 - For State Registrar	State	of Marylan	-	artment of H	Health and Death		giene Reg.No.00	6 (14981
			*	Decedent's Name (First, Michael Control of the	Idle, Last)					2. Date of De.	ath		3. Time of Death
		Physici: /Medic		Rosemary	Ei	senhaue	r			Februar	Day	Year 2006	5:25 p M
	7	Examin		4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, Town, o	or Location of Dea	th	4c. County		
	es a		0	Atlantic Gene	ral Hospit	al			Berlin		We	orces	ter
		Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h v, Year)	9. Birthp	place (State or Foreign
	Ш	Director		217-28-1723	I I W ZAIF	73	Yrs.			May 8,	1932		NJ
		and and		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
		Mary f sho	ŏ	MD	Llowanata			n1 <i>t</i>					1 ☐ Yes 21 No
		the 28a	Director	MD 10e. Street and Number	Worcester			Berlin 10f. Zip Code			10g. Citizen of	What Cour	ntry?
		3s or		8 Darby Co	nrt				811		-		, .
		death ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U.	S. 13. V	Was Decedent of I	Hispanic Origin? (Specify Yes or No		JSA ce - Americ	ean Indian,
	9	after or ita		1 Never Married 2 M	Armed F arried 1 ☐ Yes	2 🔯 No	'	t Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		ck, White,	etc.
	21215-0036	ral', c	1 by	3 X Widowed 4 □ Divord		IIVO		I∐Yes 2∭X No	Specify:		Specif	iy: T	White
	5 C	72 h natu dical	Completed		ent's Education hest grade completed)	16a. Deced	tent's Usual Occup	pation during most of wo	nrkina	16b. Kind of B	usiness/Ind	dustry
	21	vithin ne. han	ldm	Elementary/Secondary (0-12) College	(1-4or 5+)	`life. L		during most of wo		_	_	
	2	lied v lygie her t		17. Father's Name (First, Midd	(b. / ant)	3		Teacher	10 11-11-11-11-	on a CFirm Maid de		lucat	ion
	anc	ntal hed of	Be							me (First, Middle,		ne)	
	Maryland	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or itams 23s or 28a-f show traumatic avant. The Medical Exam natural be notified at	ပ	Bernard Ratt 19a. Informant's Name/Relation			10h Mailie	a Addross (Stroot	Ma1 and Number or R	ry Scabet		Ctata 7:-	Codel
	Ma	and 2 sealth an n 27 is ser trau		Tara E. Ebers		ighter	1		Ave., Cat				(2006)
	ē,			20a. Method of Disposition	оте вас	20b. P	lace of Dispo	sition (Name of		Date	20c. Location	21228 - City or To	own, State
	Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other		1 State		natory or other pla	· 1	101:106			1 200
	≣	artme ortar injur		21. Signature of Funeral Servi		Gar		Forest V		/24/06	15.0		ls, MD
	ñ	permi Depa Impo any ir		Stephe	n M.4	enter	5 F	line Fund	eral Home		Reiste		
		4		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that	caused the death						rii)	Approximate
		Physician		Immediate Cause (Final disease or condition	St only one cause on	1 ATIAR	lile	discos					Interval Between Onset and Death
		/Medical		resulting in death)	a. Due to	(or as a consequ		UN 3 CO 31					
		Examiner		Cognosticity list conditions	b								
,		D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):						
	٧	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
24	68760,	icate be executed physician and s the burial-transit	Ē	resulting in death) Last	Due to	(or as a consequ	uence of):						
ह	87	cate b	edicai		3				1.11 1.11 1.11 1.11				
5 3			/Me	IF FEMALE:	230 If you	utcome of pregna	201						
1725 1725	Вох	eath certifi attending for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 □ Fetal nant at time of de	death 3	Ectopic pregnanc	у			ite of delive onth	Day Year
Death: 2/1	Ö	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki		aun 5∟	Other (specify) _					
A	٦.	The law requires that the death certil the has been signed by the attending bage 2 should be detached for use a		Part II. Other significant cond	itions contributing to	death but not rest	alting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
	ds,	uires sign	d by							1 🗆 1	res 2 0 No	3 ☐ Prob	ably 4 Unknown
pi	ecord	w requir been si should	iete							24a. Was	an 24h	Ware auto	nev findings available
22	α	he lav	Completed							auton	sy rmed?	prior to cor death?	psy findings available impletion of cause of
193	Vital		000	25. Was case referred to medi	cal	_/			OG Diago of Do		2010	1 🗌 Yes	2 2 No
Fosemury 05 08 1932	Ž	hysician: The this certificate had director, page	0 0	examiner? 1 ☐ Yes 2 ☐ No	Hospital	Inpatient 2	ER/Outpatien	t 3 DOA Oth		ath (Check only of Home 5 ☐ Resid	2 /	or /Spacifi	<i>a</i>)
28	o l	# # #	T u	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time of	28c. Injui Wor		28d. Describe h			()
CY W	jo	death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pen 2 ☐ Accident inve	ding (MO) stigation	inii, Day 16ai)	Injury		rk? Yes 2 □No				
35	Division	r Atte	Certification		ld not be mined 28e. Plac	e of Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Numi	oer or Rura	l Route Number,
Z		rs aft ral Di	Cer	/						ony or you	, olato)		
EISEN HAUER, 217-28-1723		the Hospital or Attending hin 24 hours after death. the Funaral Diractor: After mpletely filled in by the fune	edical	Check only 2 Mean	ing Physician: To the	e best of my kno-	wledge, death	occurred at the til	me, date and plac	e, and due to the	cause(s) and ma	anner as st	ated.
い国		To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medi	-	and	nner stated.							
		To To Con	=	29b. Signature and title of cert	1	01 ~		29c. Licens	7 617		29d. Date signe		Day, Year)
	•			, 00	1	Physicia	n	VS.	1412		2/15/	060	
		w			on who completed cat	ise of death (Item 33 Heal	23a) (Type,	Print) D - B.	3612 colous p	up 26	811		
		Sta	te	31. Date filed (Month, Day, Ye		Bistrar's Signa	ture	- W					
	1	Registr		EED S	1 2006	Aut w	B A	SEASON !					

		•	1 - For State Registrar	State of M	aryland				ealth a	ınd Me		iene	06	04982
			Decedent's Name (First, Middle, Last	')						2	2. Date of Dear			3. Time of Death
	Physici		Theresa G.	Evans						F	ebruary	Day 17,	Year 2006	12:05 ₺
V	/Medic Examin		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location o			1	ty of Death	12.03 p
	Exami		Greater Baltimo	re Medica	1 Cen	ter		Tows	on			Balt	timore	2
	Funeral		Social Security Number 6. S			ast birthday)		r 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth	Vear	9. Birth	place (State or Foreign
	Director		215-30-1413] M 2□ X F	72	Yrs.	Months	Days	Hours	MIN.	B. Date of Birth (Month, Day) an 26,	1934	Ma	ryland
	P ≥		Usual Residence of Decedent 10a, State 10b, County		100 City	, Town or Lo	anlina							10d. Inside City Limits
ь	aryia sho	2	MD Baltimor	۵	1	hervi]								1 ☐ Yes 2\O\No
	18a-1	ecto	10e. Street and Number		Luc	TICI VI		0-4-				0- 0''		
	be filed within 72 hours after death with the Maryland at Hygiene. Hygiene 4 Hygiene 6 ther than "neturel", or items 23a or 28s-f show other than "neturel", or items 23a or 28s-f show event, the Madical Examinar must be notified at	Funeral Director	12040 Trallee D	rive				093			'	0g. Citizen of US.		ntr y r
	me 2	era	11. Marital Slatus	12. Was Decedent	Ever in U.S	3. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spec	ify Yes or No-		ce - Ameri	
9	after or ite		1 Never Married 2 Married	Armed Forces? 1 Tyes 2 1 If Yes, Give	No		r Yes, spe 1 □ Yes		n, Mexican Specify:	, Риело н	ican, etc.)		ack, White,	White
21215-0036	ours Fig.	Completed by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:			10 105	2(<u>A</u> NO	зреспу.			Spec	ny:	WITTEE
5-0	72 h	etec	15. Decedent's Edi (Specify only highest grad		1	16a. Deced (Give	kind of w	ork done a	turing most	of working	,	16b. Kind of	Business/In	dustry
21	hen.	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I		nagei	•			Socia	1 500	urity
2	lled v tygie ther t		17. Father's Name (First, Middle, Last)				ina	nage		r's Name /	First, Middle, i			urrey
Marylahd	permit. Peges 1 and 2 should be filed within Depertment of Heelih and Mental Hyglene. Importent: if item 27 is marked other than eny injury or other traumatic event, in Manapace.	Be C	James Gutows	l i							rgaret		,	
₹(mark mark	2	19a. Informant's Name/Relationship (T			19b. Mailir	a Addres	s (Street a			Route Number			Code)
Σ	ith and 2 is 27 is r trau		Terry Kimmel/dau	ghter					Bridg			thervi		
re,	s 1 and 14 Hee		20a. Method of Disposition			ace of Dispo	sition (Na	me of	e)	Da		20c. Location	- City or T	own, State
Ë	Pege lent o nt: if ry or		1 ☐ Burial 2 🗗 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Hil	ltop S	SVC.	Corp	. 0	2/20/	2006	Towso	n, Ma	ryland
Baltimore,	pertra porte y inju		21. Signature of Funeral service Lenn			22	. Name a	nd Addres	s of Facility	Ruck	Towson	n Fune	ral H	ome, Inc,
m	Depermine Deperm		sup St	ephen Cos	ter	1	1050	York	Road	, Tow	ison, Ma	arylan	d 212	04
			23a. Wart1. Enter the disease, or composhock, or heart failure. List only of	lications that caused ne cause on each li	the death	. Do not ent	er the mo	de of dyin	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Bre	net	00	nee	· C .	ma	fre	tation			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	++62			-100	iocii C	-		
	CXammer		Sequentially list conditions,	b		- Control of the Control								
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or se	a consuqu	ensa ut):								
	be executed sicien and burial-transit	хал	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							_	
8760,	ficate be exi physicien a s the burial	ᇤ												
687	phys s the	edical		d										
×	eath certific attending p	W.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. D	ate of deliv	erv
Вох	death atter	Clai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic p Other (s						fonth	Day Year
P.O.	thet the dead by the detached	Physician/M	9 Unknown	9□ Unknown										
۳,	s thei	by P	Part II. Other significant conditions co	ntributing to death b	out not resu	tting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use co	nIribute to t	he cause of death?
Records,	w requires been sign should be	ed									1 🗆 Y	es 2 No	3 Pro	bably 4 [Unknown
ည် ပ	e iaw requ has been je 2 shoui	Completed									24a. Was a	in 24b	. Were auto	opsy findings available impletion of cause of
Ä	The i	E									autops perfor	med?	death?	
ita	den: ortifice ctor. ;	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only or			
>	hysic his ce i dire	10	1 ☐ Yes 2 No	Hospital:		ER/Outpatien	t 3□ D	OA Othe	er: 4 □ Nu	rsing Hom	e 5 🗆 Reside	ence 6 □O	ther (Speci	(y)
o u	Attending Physician: The six deeth. After this certificete his certificete his by the funeral director, page		27. Manner of Death 1 X Naturat 5 □ Pending	28a. Dale of Inju (Month, Da	y Year)	28b. Time of Injury		28c. Injun Work	at	28	d. Describe h	ow injury occi	urred	
sio	uttendi deeth. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🔲 I					
Division of Vital	or Att	Certification:	4 Homicide determined	289. Place of In	jury - At hor ic. (<i>Specify</i> ,	me, farm, str)	eel, factor	y, office		28	3f. Location (Si City or Town	treet and Nun n, State)	nber or Run	al Route Number,
ا ب	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eiter death. To the Funerel Director: Atter this certificate has been signed by the attending physicien and compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 120 Certifying Phy	rsician: To the best	of my know	uladae daes	0000000	at the t	no data e-	d place .c-	ad due to the -	ausa(a) and		stated
	HOS 124 h	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner st	f examinati	ion and/or in	vestigation	n, in my of	pinion, dea	th occurred	d at the time, d	late and place	and due t	o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	0			29	c. License	number		2	9d. Date sign	ned (Month,	Day, Year)
	1.		I dimet l	Maln	m	0			386			Febr	uary	18,2006
	MI		30. Name and address of person who o	ompleted cause of	death (Item		Print)				. (1	7.11	.04:-	21204
	10		Aimee F.	Whea	ton	mr	2 6	701	N.C	narl	es St	Balt.	IND	21204
4	Sta Registi		31. Date filed (Month, Day, Year) EER 2. 1. 2006	32. Registr	rar's Signat	ure.	8							

DHMH 17 Rev 1/2001

Registrar

2006

FEB21

			1 - For State Registrar	State of Ma	arylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H	ealth a Death	and M		giene Rog. No.	006	0 4	981	Ì
	Physic		Decedent's Name (First, Middle, Last STELLA)	INAH	NAH		EBRI	GHT		2. Date of Dea		7, 2 ^v 00	3. Tim	e of Death	h M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o				County of De			
	Funeral Director		220 03 1000	7. Age	e (In yrs.	last birthday) Yrs.	If Under Months		If Under a		8. Date of Birt. JUL 22	,200	9. 8	lirthplace (St. Country)		ign
	tryland show		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo								i i	e City Lim	
	28a-1	Director	MD BALT:	IMORE		BALT	I MORE					10g, Citiz	en of What		Yes 2∭	.Vo
	th with	ai Di	31 IRONWOOD CIRCL	.E					212	209		•		USA	١	
	r dea	Funeral	11. Marital Status	12. Was Decedent E		.S. 13. V	Was Deced	lent of His	spanic Orig	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	1	4. Race - Ar Black, Wi	nerican India	٦,	
9036	ours afte	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 🗖 N If Yes, Give Year or Dates:			1 ☐ Yes 2		Specify:				Specify:	WH]	TE	
5	"natu	etec	15. Decedent's Edu (Specify only highest grad			16a. Deced (Give	kind of wor	k done di	urina most	of working	ng	16b. Kin	d of Busines	ss/Industry		
121215-0036	tiges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28a-1 ehow or other traumatic event, the Medical Exact and item Inditional to or other traumatic event, the Medical Exact and item Inditional and or other traumatic event, the Medical Exact and item Inditional and or other traumatic event, the Medical Exact and items of the Inditional and other traumatic event, the Medical Exact and items of the Inditional and Indiana.	Completed	Elementary/Secondary (0-12) NONE 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)	//re. L	00 NOT us		NOI		/Fina 8414-H	*****		NON	IE	
Maryland	ould be fi Mental H arked ot atic ever	To Be	MICHAEL			EBRI	GHT			ENA	(First, Middle,	Maiden S	Surname)	FOF	RMAN	
, Mar	and 2 shi alth and 127 is m ar traum		19a. Informant's Name/Relationship (Ty MICHAEL EBRIGHT /								Route Numbe					
Baltimore,	ges 1 a 1 of He If item or oth		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 💆 F	lemoval from State	20b. P	Place of Dispo- cemetery, cren	sition (Nam natory or o	ne of ther place)	Di	ate	20c. Loc	ation - City	or Town, Stat)	
Ħ.	it. Pagintment intant: njury		4 Donation 5 Other (Specify) 21. Signatur of Fungral Service Licens	1/	MT.	LEBAN							SELIN,			
Ba	permit. Pages 1 and Depertment of Healt important: If item 2' any injury or other anges.		Michael T	rugel		100	. Name an			301	LEVIN				:. 21208	
	Physician		23a. Paul 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused ne cause on each lin COMPLIC											Between nd Death	
灰	/Medical Examiner		resulting in death)	Due to (or as a										1		
./	per list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseq	uence of):										
90,	licate be executed physicien and s the burial-transit	ıl Exar	that initiated events resulting in death) Last	Due to (or as a	a conseq	uence of):										
09289	ficate t physic s the b	edicai		d												
Vital Records, P.O. Box	The law requires that the death centificate be executed tee has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 🗌 Feta	Ideath 3	Ectopic pre					23	3d. Date of d Month	elivery Day	Year	
S, D	res that the signed by be detact	by Ph	Part II. Other significant conditions cor	tributing to death bu	it not resi	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause	of death?	
ord	w require been si should b										1 🗆 Y	es 2 X	No 3 🗆	Probably 4	Unknov	₩n
II Rec		Completed									24a. Was a autops perfor 1 \(\text{Yes} \)	sy med?	prior to death?	autopsy findia completion s 2 \(\) No	igs availat of cause o	ole st
<u> </u>	Phyeician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				104	-		Check only or					
ō	tending Phyeician: leath. tor: Alter this certific the funeral director,	lon: To	27. Manner of Death 1 X Natural 5 □ Pending	1 ☐ Inpatier 28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury	28	3c. Injury Work	at)	2	e 5 Resid			pecify)		
ivisio	e Hospitel or Attending 24 hours after death. e Funeral Director: After etely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At ho	ome, farm, stre	M eet, factory,		es 2□N		8f. Location (S City or Tow		Number or I	Rural Route I	lumber,	
۵	To the Hospitei or At within 24 hours after d To the Funeral Direct completely filled in by	al Cer	29a. Certifying Physical Control of the Control of	sician: To the best o	f my kno	wledge death	occurred a	at the time	date and	I place, as	nd due to the c	3116 0 (6) 3	and manner			
	To the Ho within 24 h To the Fu completely	Medical	one)	ner: On the basis of and manner state	examina	tion and/or inv	estigation,	in my opi	nion, deati	h occurre	d at the time, o	late and p	place, and de	ue to the cau	6e(s)	
	Viii O To	<	29b. Signature and title of certifier	Bogue	M	D	29c.	License		_	2			nth, Day, Yea	,	
7	1		30. Name and address of person who co	()			Print)		37986)		FEB	KUARY	17, 20	06	
	7		LAUREN L. BOGUE,	M.D.	107	755 FAL		AD,	SUITE	260	- LUTI	HERV:	ILLE,	MD 210	193	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ture	and the same									

			For State Registrar		State	of Mai	ryland /		artmer <i>rtificat</i>			and Me	ental Hyg	giene	UUI	5	0498	35
	Physici	an.	1. Decedent's Name (First, M				_						2. Date of Dea	Day	Ye Ye	ar	3. Time of De	ath
1	/Medic	al	Clarence		lgeul		lds			_	. 1.3		'ebrua	ry	16 20	006	9:40a	1 M
1	Examin	er	4a. Facility Name (If not instituted Carroll Hos	-			•				Location o				County of E			
	Funeral		5. Social Security Number	6. S		_	(in yrs. last i	birthday)	If Unde	r 1 Year	nste If Under:	24 Hrs.	8. Date of Birt	h	arro	Birthol	ace (State or Fo	oreign
	Director		288-28-0478	1	XM 2□F	75		Yrs.	Months	Days	Hours	Min.	(Month, Da) Dec 14	1 9	30 (Count Dhi		
	and w		Usual Residence of Deceden 10a, State 10b, Cou				10c. City, To	own or Lo	cation							10	d. Inside City L	imits
	Maryli 1 sho	ro		rrol	1		Syke										1 ☐ Yes 2√	
	r 28a-	Director	10e. Street and Number						10f. Zip	Code				10g. Citi	zen of Wha	t Count		
	th with		6249 Old Wa	ashi	ngton	Rd.	ı		21	784				U	SA			
	r dee	Funeral	11. Marital Status		12. Was De Armed F	Orcas?		13.	Was Dece f Yes, spe	dent of Hi	spanic Orig	gin? (Spec	fy Yes or No- ican, etc.)	-	14. Race - A Black, V			
36	s afte	by Fu	1 ☐ Never Married 2 🔀 I 3 ☐ Widowed 4 ☐ Divor		1 Tyes If Yes, G Year or	2 □ No Sive	Kore	_	1 🗆 Yes		Specify:				Specify: V			
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show the M. dical Examinar must be notilied at	ted t	15. Dece	dent's E	ducation		16	Sa. Dece	dent's Usu	al Occupa	ation			16b. Ki	nd of Busine	ess/Ind	ustry	
215	thin 7:	Completed	(Specify only hi	-	· · · · · · · · · · · · · · · · · · ·	() (1-4or 5+))	life.	<i>DO NOT</i> u	se retired,							tions	
N	ygien ygien t, Ite	Соп	12					tel	.epho	one	repa					.ca	LIONS	
and	should be filed within 72 hours after deeth with the Marylan nd Meddal Hygjen. marked other than "natural", or Items 23s or 28s-1 show mailc event, Its M.olical Examinar must be notilied at	Be	17. Father's Name (First, Mid Edgeul E		,								(First, Middle, kins	Maiden	Sumame)			
Maryland	should ind Men ind Men ind marke	ဥ	19a. Informant's Name/Relat				1	9h Mailir	na Addres	S (Street a			Route Numbe	er City o	r Town Sta	te Zin i	Codel	
			Myrna Field			e)							Rd.,				217	84
altimore,	of Hee		20a. Method of Disposition				20b. Place ceme					Da	-		cation - City			
Ĕ	Peges nent of l ant: If Its ury or o		1 ☐ Burial 2 ြ Cremati 4 ☐ Donation 5 ☐ Othe			n State	i		inty			2-18	-06	Syl	kesvi	110	e, Md	
Balt	permit. Peges 1 and 2 Department of Health a Important: If Item 27 Is sny Injury or other trau once.		21. Signature of Funeral Sen			tre		22	. Name a	nd Addres	s of Facilit	y Hai	ght F	unei	ral H	ome	e & Ch	a pe
			23a. Part1. Enter the disease	or com	plications that	caused th	he death. D						esvil		Md 2		8 4 Approximate	
	December		shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line					,,		,			1	Interval Betwee	en ith
1	/Medical		disease or condition resulting in death)	-	a Due to		consequence									L	trys	
	Examiner		Sequentially list conditions.		b (ere	brow	rasi	cla	a	ceid	lart	-			1	lears	
7	sit ad	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	o (or as a	consequenc	æ ofj.										
V	and and Il-tran	xam	that initiated events resulting in death) Last	1	c	(or as a	consequenc	e of):								1		
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9	tificati ig phy as the	ledic			_ 0.													
Box	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, o		pregnancy	ath 3□	Ectopic p	regnancy				2	23d. Date of		*	
о Ш	that the death certified by the ettending deteched for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at ti	me of death		Other (sp					ļ	Month		Day Year	r
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Ö	s beer	Completed											24a. Was	an	24b. Wer	e autop	sy findings ava	ilable
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Vital		Be C	25. Was case referred to med examiner?	tical							26. Place	of Death	Check only o			103		
<u>5</u>	Physiclan: r this certifice ral director, I	ဥ	1 ☐ Yes 2 ☐ ASTO			Inpatient	-		_		4 🗀 140		e 5□Resid			Specify,	1	
Division of	ding Ph h. Alter th futeral	i o	27. Manner of Death 1 Natural 5 ☐ Pe			of Injury onth, Day	Yeer) 28b	. Time of Injury	м 2	28c. Injury Work			3d. Describe I	now injur	y occurred			
1810	or:	fical	3 ☐ Suicide 6 ☐ Co	estigation uld not b termined	e One Plac	e of Injun	y · At home,	farm, str			/es 2 ☐ f		of Location (5	Street are	d Number o	r Rural	Route Number,	
2	s after s after al Dire	Certification:	4 Homicide	emined	build	ding, etc.	(Specify)			,,			City or Tov	vn, State,)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	'
	To the Hospitel or Atl within 24 hours after o To the Funaral Direc completely filled in by	edicai	29a. Certifier 1 Cert (Check only one)	fying Ph cal Exa	nysician: To the	ne best of basis of e	xamination	ige, death and/or in	occurred restigation	at the tim , in my op	e, date an	d place, ar th occurred	nd due to the	cause(s) date and	and manne place, and	r as sta due to	ited. the cause(s)	
	To the	Me	29b. Signature and title of cer	tifier	and ma	state			290	c. License	number			29d. Dat	e signed (M	lonth, E	lay, Year)	
		1	· Wille 6	1/2	me	2				100	580	37			2/16	10	6	
	2	- 13	30. Name and address of per	ion who	completed cau	use of dea	ath (Item 23a	a) (Type,	Print)	1 ,	4	,	M	0 -	2			
	Sta	te.	31. Date filed (Month, Day, Y		200	Registrar	's Signature	>+	27/	W	955N	unst f			4113	/		-
	Registr		FEB 2	1 21	006	Page .	N.		34520									

		For State Registrar	State of Marylar	d / Depa		Health and	Mental Hyg	•	04986
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La. MARY RENE 4a. Facility Name (If not institution, giv HARBOR HOSPI	FREEMAN street and number)		4b. City, Towr	n, or Location of Deal	2. Date of Dea Month FEBRUARY		6 10.10 MM
- Funeral Director		5. Social Security Number 6. S 201-14-3007 Usual Residence of Decedent	ex 7. Age (In yrs. X 83	last birthday) Yrs.	If Under 1 Ye Months Day			, 1922 Per	irthplace (State or Foreign Sountry) insylvania
Maryland a-f show	ctor	10a. State 10b. County Maryland n/a		y, Town or Lo altimo					10d. Inside City Limits 1 Yes 2 □ No
h with the	al Dire	10e. Street and Number 600 Light Street	Apt. 612		10f. Zip Cod	230	1	Og. Citizen of What Countried	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Itam 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Modical Examinations to infilied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	
d within 72 ho giene. ir then "natur the Medical	Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12) unknown	trucation de completed) College (1-4or 5+) unknown	(Give	DO NOT use ret	ne durina most of wo	rking	16b. Kind of Busines	
ould be filed Mental Hyg Larked othe Latic event,	To Be C	17. Father's Name (First, Middle, Last) Unknown	Doyle			Unknown	me (First, Middle,		
and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Scott Blaha (neph	ew)	1105	S. Roll	ing Road		r, City or Town, State, e, MD 21228	
Pages 1 tment of H tant: if its		20a. Method of Disposition 1 ← Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Mar		sition (Name of matory or other p Veteran		27-2006 G	20c. Location - City of Sarrison Fo	
permit Depar Impor any in			. Wayne Osterl					Home, P.A. e, MD 212:	30
Physician /Medical		as. Part1. Enter the disease or come shock, or heart lailure. List only Immediate Cause Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. HYPOTENS Due to (or as a consec	NON	er the mode of o	tying, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death TWO DAYS
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGESTIL Due to (or as a consec	UE HE uence of):	ART FA	NURE			Two Days
the death certific y the attending p ched for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregna Other (specify)			23d. Date ol d Month	elivery Day Year
wrequires that the de been signed by the should be detached	ed by Pt	Part II, Other significant conditions of SEVERE OSTEO		ulting in the u	nderlying cause	given in Part I.		4	to the cause of death? Probably 4Unknown
sician; The law restrictions to serificate has bee	Completed	PHEUMONIA					24a. Was a autop: perfor 1 ☐ Yes	sy prior to med? death?	autopsy findings available completion of cause of
nysician nis certifi director	To Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 npatient 2	ER/Outpatier	nt 3 DOA	Other	ath <i>(Check only or</i> Home 5 ☐ Resid	ne) ence 6 ∐Other (Sp	pecify)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		28b. Time of Injury	M 1	njury at Vork? Yes 2 No		ow injury occurred	
oital or Ati urs after d oral Direct		4 Homicide determined	building, etc. (Special	y)			City or Tow		
he Hosp in 24 ho he Fune pletely fi	Medicai	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death tion and/or in	n occurred at the vestigation, in m	time, date and place y opinion, death occ	e, and due to the durred at the time, o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
To t	Σ	29b. Signature and title of certifier MOMUSA -	INTERN			ense number	_	29d. Date signed (Mo.	
2		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	.ES000		TEBRUARY	IT KUDO
√ Sta	e.	AMUSA NTATIN 31. Date filed (Month, Day, Year)	HARBOR H	OSPITA	<u> </u>				
Registra		FEB 2 1 2006	Been A A	rest					

			State of Maryland / Department of Health and No. 1 - For Amend Item#5 per FH G852 2/21/06 CC Registrar	Mental Hy	ygiene Reg. No.	006	04987
	ysicia		1. Decedent's Name (First, Middle, Last) MARY EUXABETH FARMER	2. Date of D Month 02 · 16	Day	Year	3. Time of Death
	ledica amine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			County of Deatl	
Ex.	Em S	-	1128 WEST FRANKUN 5. Social Security Number - 6. Sex 7. Age (In vrs. last hinthday) If Under 1 Year If Under 24 Hrs.	1		NA	
Fun. Direct			1 M 20 F Q5 Yrs. Months Days Hours Min.	8. Date of B (Month, D	irth Pay, Year) • 1910	9. Birth	nplace (State or Foreign untry) VA
land wo	=	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Many Many	Illed	ţo	MD N/A BALTIMORE				1 Yes 2 No
2.6.05 th with the Ma	a not	ire Pire	10e. Street and Number 10f. Zip Code		10g. Citiz	en ol What Co	untry?
- 2 .	reat	by Funeral Director	1128 WEST FRANKUN 21223			AZU	
DOVO - 036 urs after deal	TOOL TO	E	11. Marital Status 12. Was Decedent Ever in U.S. Ammed Forces? 1 □ Never Married 2 🔀 Married 1 □ Yes 2 💆 No	pecify Yes or N o Rican, etc.)	10-	 Race - Amer Black, White 	
Δ0V) - 2. (6.05 T 5-0036 72 hours after death with the Maryland return!; or Hems 23a or 28a-1 show	Exar	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			Specify: BLA	ick
72 27		Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king		d of Business/l	
within Kithin	De Me	dwo	Elementary/Secondary (0-12) 12 TH GRAOE NA CHEF		SEL	e ene	WYED
other parents	avent, the Ms	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle			WILD
Irylar should be marked marked	atic a	2	EUGENE NEWTON ELEANOR	OT AS	HNSO	N	
Mary Mary 12 should he and M	other traumatic	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rul 2.4 2.2 2.2 2.2 2.2 2.2 2.2 2.2 2.2 2.2				ip Code)
ore, M	ther	1	BARBARA DIXON (DAUGHTER) 1319 PENTRIDGE RD. B	Date Date		21239 ation - City or	Fown State
N 0 00-	ry or c		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory or other place) Commetter Com	. 0		o. MD	own, olais
Baltimore permit. Pages 1. Department of He Important: If item		ł	21. Signature of Fuperal Service Licenses VAUGHN C. GREENE FU				
1 × m &&E	Sud Buc Buc Buc Buc Buc Buc Buc Buc Buc Buc		5151 BAITO NATU PIRE	BAUTO.	MO &	J224	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physic /Med			Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILU	RE			Criset and Death
Exami			Due to (or as a consequence of): Sequentially list conditions b. Aor +1C - Shen DS IS				
(2)		ner	if any, leading to immediate Due to (or as a consequence of):				
D, C	transi	Examiner	Cause (Disease or injury that initiated events c.				
68760, ficate be executed physicien and	burial	e E	Due to (or as a consequence of):				
68760, ificate be ex		edicai	d				
Box 6 Bath certifi		Z	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23	3d. Date ol deli	very
Vision of Vital Records, P.O. Box (Attending Physician: The law requires that the death certificate. Cleath. ector: Atter this certificate has been signed by the attending	should be detached for use	Physician/M	in the past 12 months? 1			Month	Day Year
P.O. thet the de by the	detact	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23e Did	tobacco us	a contribute to	the cause of death?
Division of Vital Records, F or Attending Physician: The law requires the after death. Director: After this certificate has been signed	ed b	٥	Blood loss are to peptic vicer	_	Yes 2	240.0	bably 4 Unknown
aw requ	2 shot	piete	and Helicobacter pulori	24a. Wa	s an	24b. Were au	topsy findings available
I Re(The lay	раде	Completed	19/01/	auto perf	opsy formed? 2 X No	death?	ompletion of cause of
Vital Fisicien: The certificate	ocio.	Be	25. Was case referred to medical examiner? 26. Place of Deat			1 103	20.100
Of N Physi	ا طَدَ	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			☐Other (Spec	ufy)
On Ading	fune true	E e	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	28d. Describe	now injury	occurred	
VISI Atter	ğ ‡	Certification:	3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	28l. Location	(Street and	Number or Ru	ral Route Number,
Di urs after rel Di	E Pe				own, State)		
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this	letely fr	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the rred at the time	n causa(s) c , date and p	and mannur as place, and due	stated. to the cause(s)
To th within To th	ф	₩ Me	29b. Signature and title of certifier 29c. License number	,	29d. Date	signed (Month	, Day, Year)
	/		pavid Silver Do HD043234	4	Febru	gary 16	, 2006
1-			30. Name and address ol person who completed cause of death (Item 23a) (Type, Print)		L	8 212	10.11
1000	Stat	6	DAVID SILVEK DO 3509 Bustern AV Salt 31. Date filed (Mogity Day, Year) 32. Registrar's Signature	Im or	c M	1 21-	224
Re	gistra	ır	31. Date filed (Month, Day, Year) FEB 2 1 2006 32. Registrar's Signature				

		Decedent's Name (First, Middle, Last)		2. Date of De		3. Time of Death
siciar	_	Gordon Fairbanks		January	Day Year 7 12, 2006	5:00 PM ^M
edica imine:			4b. City, Town, or Location of		4c. County of Dea	
		Joseph Richey Hospice	Baltimore			
ral		1₩ 2□E	If Under 1 Year If Under 2 Months Days Hours	Min. (Month, Da	ly, Year) Co	thplace (State or Foreign ountry)
or	-	220-80-8296 31 Yrs. Usual Residence of Decedent		Feb 17	, 1974 Mar	yland
	_ } _	10a. State 10b. County 10c. City, Town or Local	ition			10d. Inside City Limits
3	0	MD Baltimore	2			1.☐ Yes 2☐ No
Sie	by runeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
To a	2	2200 Wilkens Avenue #3	21223		USA	
	N C	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Wa	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ame Black, Whit	
	, a	1 Never Married 2 Married 1	Yes 2 No Specify:		Specify: wh	nite
	3	15. Decedent's Education 16a. Deceder	nt's Usual Occupation		16b. Kind of Business	Andustry unk
9	Completed	(Specify only highest grade completed) (Give kir life. DO	nd of work done during most O NOT use retired)	of working		
Č	0 -	12 0 wareho	ouse worker			
	מ	17. Father's Name (First, Middle, Last)		r's Name (First, Middle,		
-	2	Gordon Leraoy Fairbanks			en Benvengi	
			Address (Street and Number			•
	-	Cheryl Dabrasky/sister 1825 V 20a. Method of Disposition 20b. Place of Dispositi	Wilhelm Stree	Date	e, MD 2122. 20c. Location - City or	
		1 Burial 2 Acremation 3 Removal from State cemetery, cremat	tory or other place)			· · · · · · · · · · · · · · · · · · ·
	H	4 □Donation (\$\paraille \paraille	Name and Address of Facility	2/02/2006 Wesley Ch		neral Home
		S Wade, Director Ste	te Anatomy Po	471 655 W.	stern Ave.,	Ctro-+2123
al er		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Arrhythmia	cardiac or respiratory ai		Interval Between Onset and Death
cai Evaminar	ŭ	Immediate Cause (Final disease or condition esulting in death)	re a hy	pother	HEDICAL EXAMINER	
ioni		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	re a hy	pother	-	Onset and Death
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Tacifor / Calciored of Potology / Calciored	to be completed by Physician medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to the significant conditions contributing to the signif	ctopic pregnancy other (specify) erlying cause given in Part 1. 26. Place 3 DOA Other: 4 Nur 28c. Injury at Work?	23e. Did to 1 24a. Was autop perfo 1 Yes of Death Check only of 28d. Describe I	23d. Date of de Month 23d. Date of de Month 23d. Date of de Month 24b. Were a prior to death? 21No 1 Yes 24h. Were a prior to death? 21No 1 Yes 24h. Were a prior to death? 21No 1 Yes 24h. Were a prior to death? 21No 1 Yes 24h. Were a prior to death? 21No 1 Yes 24h. Were a prior to death? 25No 1 Yes 24h. Were a prior to death? 25No 1 Yes	Onset and Death 2 Iivery Day Year o the cause of death? robably 4 □Unknown utopsy findings available completion of cause of
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Virginia 3:30 AM Feb. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Roland Park Mahor Baltimore N/A Care | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | April 28 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-34-4792 1 ☐ M 2 🕱 F Director Martland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Baltmore Cockeysville 1 ☐ Yes 2 X No Directo Maryland 10e. Street and Number 10g. Citizen of What Country? ŏ Hilar 23a 17 21030 United by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or item any injury or other treumetic. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Union Memorial Hospital Tg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Graver Pear Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Funk 8180 Forest Glen Drive, Pasadena Maryland, 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Feb 21,200 Forest Hill, Maryland Evans Chanel * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Pencet Alternatives Funeral and Cremation contents. A.
23. S York Road T. monium Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEBILI disease or condition resulting in death) /Medical Due to (or as a consequence Examiner ROLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The taw requires that the death certificate be executed DEMENTIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 No 1 ☐ Yes 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fr 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNE BALTIMO 52. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 1 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23 (PI), Pstate of Maryland / Department of Health and Mental Hygiene
1- For Amend Item#4c per FH G852 2/21/09 rifficate of Death
Registrar
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:30 AM 13,2006 DILLAM /Medical Facility Name (If not institution, give street and number) 4c. County of Death BALTTMORE 4b. City, Town, or Location of Death **Examiner** benesis Elder Rendallstown, mary land 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 237-66-045 100 M 2□F Yrs Pennsylvania Director 64 15,194 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "neturel", or Items 23e or 28a-f show the Mcdical Examinar must be notified at 1 Yes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Violet Avenue 21215 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Morgan State University Security other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Mental s 1 and 2 should b f Health and Ments item 27 Is marked Maggie Foster William Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 McMechen street Baltimore, Maryland 21217 Katherine Williams If Item 2 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 02/15/06 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complete ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIR Physician /Medical Due to (or as a consequence of): Examiner Planal Effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical d guipu IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 2 1 ☐ Yes 1 🔲 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: ဥ 1 Tyes 2 No 4 Surring Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Death 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. Nicense number 29d. Date siggled (Month, Day, Year) PARK 30. Name and address of person who completed cause of death (Item 23a) (Type, Privil to wo An HI 1340 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

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	danyla f shov	ō	10a. State 10b. County Maryland Baltimore	106. 0	ity, Town or Location	n				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Director	10e. Street and Number		10	of. Zip Code		10g.	. Citizen of What C	
	23a o		512 Back River Neck	Rd.		212	21		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23e or 28e-f show styling or other traumatic event, the Medical Examinar must be invitted at ance.	d by Funerai	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in t Armed Forces? 1 XYes 2 No If Yes, Give WW Year or Dates:	If Yes	Decedent of Hi , specify Cuba es 2 🖾 No	spanic Origin? (s n, Mexican, Puei Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
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Maryland 2	wild be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Robert W. Finnick S.	r.			18. Mother's Na Mary R.	me (First, Middle, Mai Byer		
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Baltimore,	ages 1 and of Hear if itam or other		20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ Ren	noval from State	Place of Disposition cemetery, crematory	or other place	g) 1 2/20		Location - City or	
altin	permit. Pa Departmer Important eny injury		4 Donation 5 Other (Specify) 21. Sign ture / Funeral Service Licensee	() ()	yview Cre		1	al Home P.A		Maryland
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<u> </u>	Attending Physician: r death. ector: After this certifica by the funeral director;	cati	2 Accident investigation		М	1 🗆 Y	es 2 No			
2	ital or Atten	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. <i>(Specil</i>	ome, farm, street, fa fy)	ctory, office		28f. Location (Street City or Town, St	t and Number or Ri tate)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier 1 ar Certifying Physici (Check only one)	an: To the best of my kno On the basis of examina and manner stated.	owiedge, death occu ation and/or investiga	rred at the time ation, in my opi	e, date and place inion, death occu	, and due to the cause irred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To th To th comp	Me	29b Signature and title of certifier			29c. License	_		Date signed (Mont	h, Day, Year)
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	H		30. Name and address of person who comp	leted cause of death (Item	n 23a) (Type, Print) 10 (りわ)	1A0 EZ	OHIA R	d. Bourn	Wist. M	W 21237
	Sta Registra	te	31. Date filed (Month, Day, Year) FEB 2 1 2006	32 Registrar's Signa	ature Age 4	0				

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			1. Decedent's Name (Firs	st, Middle, L	.ast)								2. Date of De Month	ath Day	Year	3. Time of Death
-	Physici /Medic		Sharon Flet										02-19			2:35 A M
	Examin	er	4a. Facility Name (If not in			umber)					Location	of Death		4c. Co	ounty of Death	n
			Joseph Rich 5. Social Security Number		Spice Sex	7. Age	(In yrs. last	birthdav)	Balt If Under		If Under	r 24 Hrs.	8. Date of Bir	th	9. Birth	nplace (State or Foreign untry)
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\mathcal{Am} Am Baltimore. Marvland 21215-0036	ges 1 and 2 should be filed within 72 hours efter deeth with the Marylan it of Heelin and Mental Hygiane, and Heelin 23a or 28a-f show or other traumatic avant, the Modical Examiner must be notified at		19a. Informant's Name/F		(Type, Print)					•			al Route Numb			
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2/19/06	irres that the death certificate be executed Example and many signed by the attending physicien and doe detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to	o (or as a		A I 'nce of):								Interval Between Onset and Death
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<u>د</u> ک	requires that the		Part II. Other significant	conditions	contributing to	death bu		•			en in Part	1.	23e. Did			the cause of death?
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T SE	Physician: this certific ral director,	Be	25. Was case referred to examiner?	medical	Hospital:					Oth			h (Check only			Fasteras
0	Phys rat dii	 To	1 Yes 2 No 27. Manner of Death		28a. Date	of Injury	t 2 ER	b. Time o		Bc. Injun Worl			me 5 Res			CITY)
0	Attanding r death. actor: After y the fune	ation	1 Natural 5 [2 ☐ Accident	☐ Pending investigat		nth, Day	Year)	Injury	м		k? Yes 2.⊑]No				
OLTO P Division	at or Attails selter dea	Certification:		Could not	28e. Plac		ry - At home (Specify)	e, farm, str	eet, factor	y, office				Street and I wn, State)	Number or Ru	ural Route Number,
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	To th To th	×	29b. Signature and title of	of certifier	/ \ ^				1		e number				signed (Monti	
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	2		30. Name and address of AYMOND). WI	724 Wi				Print) 4 AIRCE	.5 5.7	, 5 m	176 4	16, BA	LT111	ore in	\$ 21204
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ORIGINAL

Registrar

			1 - For	State of Mai	ryland	Departme / Departme			lental Hy	giene Reg. No.	06	049	94
			Registrar 1. Decedent's Name (First, Middle, Las	t)		COMMO	10 01 01		2. Date of De			3. Time of	Death
3	Physici	an	TA (20	" C	Con	RDN.	SP		FEBRUA!	RY 16 2	Year		РМ
1	/Medic	al	JAMIES	<u> </u>	717			ocation of Death			inty of Death	3:10	Р
1	Examin	er	4a. Facility Name (If not institution, give 1425 Race Street				Baltimo			40. 000	,		
					(In yrs. las			f Under 24 Hrs.	8 Date of Bi	th.	n/a	lace (State o	v Foreign
8	Funeral			X 2□F 8		Yrs. Month		Hours Min.	8. Date of Bi	3 - 23	Cour	try)	, roloigi.
45	Director		Usual Residence of Decedent	Λ 0.					8-1	3 - 2) Hary	Tana	
	and and		10a. State 10b. County		10c. City, 7	Fown or Location					1	0d. Inside C	ity Limits
	Mary f sho	ō	Maryland n/a		R	altimore						1 Yes	2 🗌 No
	the l	Director	10e. Street and Number				Zip Code			10g. Citizen	of What Cour	itry?	
	with with	۵	1425 Race Street			2	1230			United	State	s	
	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "netural", or iteme 23a or 28a-f show event, the Medical Exam har must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.			anic Origin? (Sr Mexican, Puerto	ecify Yes or No	o- 14. F	Race - Americ		
	lter d	FE	1 Never Married 2 Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give					Hican, etc.)		Black, White,		
33	urs a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WW II	1 L Yes	2 X No .	Specify:		Spe	ecify: WIN	ite	Ĭ
ŏ	2 hor	Completed	15. Decedent's Ed			16a. Decedent's U	sual Occupation	on	rina	16b. Kind o	f Business/In	dustry	
715	n n n	ple	(Specify only highest gra	College (1-4or 5+)	life. DO NO	Tuse retired)	ing most of wor	w.				
21	d wit	mo:	12 years			Truck Dr					king		
b	e filed within al Hygiene. other than vent, the hygiene.	Be C	17. Father's Name (First, Middle, Last)				18	8. Mother's Nam	e (First, Middle	, Maiden Sun	name)		
lar	Mental Mental arked c	To E	William Rowe Gar	dner				Edith	Leona H	laddawa	.y		
Maryland 21215-0036	s 1 and 2 should f Heelth and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7			19b. Mailing Addr					wn, State, Zip	Code)	
	elth a		Nancy Hadaway (da	ughter)	1	1425 Rac	e St. E	Baltimor	e, MD	21230			
Baltimore,	s 1 a		20a. Method of Disposition		20b. Plac	e of Disposition (inetery, crematory)	Name of or other place)	1	Date	20c. Location	on - City or To	wn, State	
Ē	Pages ment of ant; if it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ced	ar Hill	Cemeter	ry 2-20	-2006	Brook	lyn Pa	rk, MI)
alti.	교문원을 .	- 37	21. Signature of Full and Service Licen	see		22. Name	and Address	of Facility niak Fu	nomol U	Iomo D	Λ.		
m	Depa impo any i		J.	Wayne Osto	erlin	8 130 E	Fort	Ave. BA	llerai n ltimore	MD	21230		
	* 17		23a. Part1. Enter the disease, or component of book, or beart failure. List only	olications that caused t	he death.	Do not enter the n	node of dying,	such as cardiac	or respiratory	arrest,		Approxima Interval Bet	te tween
	Physician		Immediate Cause (Final	AMA A	an. Le	nce of): Ktdn ince of): Lee	UTT	rilas.	, 10	218-7	2	Onset and	Death
1	/Medical		disease or condition resulting in death)	a. Due to (o/as a	conseque	nce of):	11.40	u w	1,64	0 -			
	Examiner			Sich	51	ma !	fund	rome	/				
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V	d d ansit	Examiner	Cause (Disease or injury that initiated events	· Chros	ic	Kran	e, Di	sease					
o	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):		· nem	9)				
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68	leath certificate b attending physic I for use as the b	Physician/Medi								-			
Вох	h cer endir	Z/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			c pregnancy			23d.	Date of delive		Year
	deat	lCig	in the past 12 mooths?	4□Pregnant at ti 9□ Unknown							Month	Day	1 Gai
0	t the de by the tached	hys	9 Unknown	3 CHKHOWH	-			- The second					
Ö,	The law requires thet the death certifica sie has been signed by the atlending ph page 2 should be detached for use as it	by F	Part II. Other significant conditions of	- 1 11	1 4	ing in the underlyin	ig cause given	in Part I.		tobacco use			
Vital Records,	w require been sig should b		utaly t	Thes le	4	71			1	Yes 2 H	6 3∐Prot	ably 4 🗌	Unknown
00	aw requ s been 2 shoul	Completed	Cellulite	left 1	low	er er	fum.	uti	24a. Wa	s an 2	4b. Were auto	psy findings	available
Re	The lav	E							perf	ormed? 2 ☑ No	death?	21 No	
ta		0	25. Was case referred to medical	-				26. Place of Dea					
>	ysicii is cer direct	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien	t 2 🗆 EF	P/Outpatient 3□	DOA Other:	4 🗌 Nursing H	ome 5 Ares	idence 6	Other (Special	(y)	
of	Ph)	12	27. Manner of Death	28a. Date of Injury (Month, Day	(Vaze) 2	8b. Time of Injury	28c. Injury a Work?	it	28d. Describe	how injury oc	ccurred		
ion	nding th.: Afte	ate	1 Aratural 5 ☐ Pending 2 ☐ Accident investigation		1041)	M		s 2 □No					
Division	Attendia r death. ector; A by the fu	=	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At hom	e, farm, street, fac	tory, office		28f. Location	(Street and Nown, State)	umber or Run	al Route Nur	nber,
ā	To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerei Director: After this certific completely filled in by the funeral director.	Certification:		Dullaling, etc.	(Chours)					,			
	hour:		29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of i	my know	edga daath conur	rad at the time	date and place	and due to the	cause(s) and	d manner as s	tated.	c)
	ne Ho n 24 ne Fu	Medical	(Check only 2 Medical Examone)	and manner stat		n and or mvestiga	don, in my opir	non, ueau occu	THE BUT OF THE				-/
	To the within 2. To the complet	Σ	29b. Signature and title of certified	el. 1.6	LA A	51	29c. License r				igned (Month,		
			CAPIDE HE	ATA LING	2416	SR.MO	DI	18426		Februs	2917.	2006	
	11011		30. Name and address of person who	completed cause of de	ath (Item 2	(Type, Print)				-	0		
	C		CATZLOS N. PATA	LINGHUG		40 37	21 807	1847L TEE 57	- BAL	T.ML	212	25	
	Sta	ite	31. Date filed (Month, Day, Year) FEB 2 1 2006	32. Registra		TO COLOR							
2.	Regist	rar	LED T T SOND	Belleville.	Des de	7							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia Ann Goss February 18, 2006 9:10 A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 M Brook Farm Ct. Perry Hall Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 162-26-7384 72 Yrs. Director 1933 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 M Brook Farm Ct. 21128 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene. Informatic if item 27 is marked other than "natural", or ite important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Exant any ang. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Monitor Tech Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert A. Stevens Ruby R. Bortner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Routzounis (daughter) 9100 Bowline Road, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem'l Park 2/22/2006 Baltimore, Maryland 21. Signature of Funeral Service icensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUELODYSPLASTIC 2 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and tor use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ♣No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 →No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Atter thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 KNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Clearly overgettris D15546 feb 20,2006 of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blot, Baltimore, hus 21239 32. Registrar's Signature State 2006 Registrar

			1 For State	State of Ma		d / Depa	rtmen		ith and N	Mental Hy	giene	006	04996
		-	Registrar 1. Decedent's Name (First, Middle, Last)				moan	0 0 00	201	2. Date of Dea	Reg. No ath		3. Time of Death
٠	Physici		Florence Guion							Month Februa	Day	7, 2006	11:55 P.
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or Loca	ation of Death	rebrud		County of Death	
1		1964	Ridgeway Manor Nu	rsing Hom	ne		Cato	nsvil]	_e			Baltimo	re
	Funeral	E CORN	5. Social Security Number 6. Sex	7. Ag M 25√F	e (In yrs. I	last birthday)	If Under Months		Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	y, Year)		place (State or Foreign intry)
83	Director		052-03-0075 Usual Residence of Decedent	86	i	Yrs.				July 1	0, 1	919 Eng.	land
	land ow		10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits
	Mary Feb	tor	Maryland Baltimor	е	C	atonsv	ille						1 ☐ Yes 2 🙀 No
	or 28a	Director	10e. Street and Number				10f. Zip	Code			10g. Cit	izen of What Cou	untry?
	23a c		P. O. Box 21032					2122	.8		US	<u>A</u>	
	r dea	nei		2. Was Decedent Armed Forces?		S. 13. V	/as Deced Yes, spec	ent of Hispar offy Cuban, M	iic Origin? (Sp exican, Puerto	ecrfy Yes or No Rican, etc.)		 Race - Amer Black, White 	
36	s afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 ! If Yes, Give Year or Dates:	No	1	☐ Yes	2 XX No Sp	ecity:			Specify: Wh:	ite
9	within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28s-f ehow he Mudical Exami in musice notified at	Completed by Funeral	15. Decedent's Educ	ation		16a. Deced	ent's Usua	al Occupation			16b. K	ind of Business/l	ndustry
212	nin 72 In "na Marci	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(4)	(Give F	and of wor O NOT us	rk done during se retired)	g most of work	aing			·
2	giene giene r the	Com	8	00110g0 (1 401 c		Asser	nb1y	Line W	orker		H	ragranc	e
D	be filed tal Hygid d other event,	Be	17. Father's Name (First, Middle, Last)							e (First, Middle,	Maiden	Sumame)	
yla	should hand Ment	T _o	John Mawdsley						n Sedd				
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Typ. John Guion Son			1		-			-	e, MD 2	
e,	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow or other traumatic event, The Madical Examplar in must be conflied at		20a. Method of Disposition		20b. P	lace of Disposemetery, crem			-	Date		ocation - City or 1	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other ance.		1 Burial 2 □ Cremation 3 Real of the Survival of the Surv	emoval from State		emetery, crem en-Woo			2/22	/2006	Broo	klyn, N	ow Vork
ቜ	artme ortan injur		21. Signature of Funeral Service License	h () /	7	1/22	Name an	d Address of	Facility Ste	rling A	shto	n Schwa	b Witzke
ñ	Depa Impo eny is		Beman)	151	200	dux	unera	1 Home	of Ca	tonsvil	le,	Inc.	MD 21228
ic.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused	the death	n. Do not ente	r the mod	e of dying, su	ch as cardiac	or respiratory ar	rest.		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as									0
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	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	derica or).							
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760,	m 03 m	call	L _a										
89	leath certificate attanding phy I for use as the	Jedi	IF FEMALE:										
Box	th ce tandii or use	an/h	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth			Ectopic pr	egnancy				23d. Date of deli- Month	very Day Year
o.	the all	Physician/Med	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of de	eath 5	Other (sp	ecify)				NOTO	Day Tou.
۵.	The law requires that the death certifica ate has been signed by the attanding ph page 2 should ba detached for use as th	Ph	Part II. Other significant conditions con	tributing to death b	ut not resi	ulting in the un	derivina c	ause given in	Part I.	23e. Did to	bacco	use contribute to	the cause of death?
Vital Records,	uires tha signed id ba dei	ompleted by								101	res 2	□No 3□Pro	bably 4 Unknown
202	w requir been si should	lete	aker, later a	arlivos	ula	dise	ane			24a. Was	an	24b. Were au	topsy findings available
Re	he tav e has age 2	duo									med?	prior to death?	ompletion of cause of 2 No
ita	ysician: The lav is certificate has director, page 2	ပ	25. Was case referred to medical					26.	Place of Dear	1 ☐ Yes th (Check only o		10105	2 140
	Attending Physician: r death. sector: After this certific. by the funeral director.	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 🗌 Inpatie	ent 2 🗆	ER/Outpatient	3 🗆 DC	A Other: 4	Nursing H	ome 5 Resid	dence	6 □Other (Spec	rity)
n o	ng Ph (ter th		27. Manner of Death 1 SQNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		8c. Injury at Work?		28d. Describe	now inju	ry occurred	
<u>s</u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Yes	2 No	201	2.		
Division of	or Al	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At no c. (Specify	me, tarm, stre	et, factory	r, office		City or Tov			ral Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a Certifier 1 Certifying Phys	ician: To the bast	of my kno	wlados dasth	Semuresch	at the time. d	abe avid okana	and due to the	causa(s	and narrier as	stotad.
	1 24 h	Medical	(Check only 2 Medical Examination)	er: On the basis o and manner st	f examinai	tion and/or inv	estigation	, in my opinio	n, death occur	red at the time,	date and	d place, and due	to the cause(s)
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier	^				. License nur				te signed (Month	
	di		Maila Kyelan	Ju m.p.				D24	781	5.	2	120/06	
9		1	30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type, F	Print)	21-77) 0	2	21	120/06	
	1		I MAIL	J-1 -1) <i>L</i>					1111 6			
) Sta		31. Date filed (Month, Day, Year)	32. Registr		7	121	, _ , _	. ,,				

			For State Ragistrar		State of	f Marylar		artment of			lental Hy	giene Rag. No.	006	04997
			1. Decedent's Name (First	st, Middle, La	st)		•				2. Date of De	ath	. It v	3. Time of Death
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1	/Medio Examin		4a. Facility Name (If not i					4b. City, Tow	m, or Loca	ation of Death	1 = 131721	- 1	County of D	
1		eı	Northwest H	•				Rar	dall	stown			Baltin	nore
			5. Social Security Number			7. Age (In yrs.	last birthday)	If Under 1 Ye		Inder 24 Hrs.	8. Date of Bir	th		Birthplace (State or Foreign
	Funeral Director			1	□M 2 Z F	86	Yrs.	Months Da	iys Ho	ours Min.	(Month, Da	sy, Year) 3/192		Country) Maryland
	Director		219-01-7889 Usual Residence of Dece			00		1			2/13	0/192	.0 1	nal y Lanu
	land			. County		10c. Ci	ity, Town or Lo	ocation						10d. Inside City Limits
	Marylan f show	ō	MD B	Baltimo	re		Ca	tonsvil	l1e					1 ☐ Yes 2 No
	the 28a-	Director	10e. Street and Number					10f. Zip Cod	de			10g. Cit	izen of What	Country?
	with	ā	4 Kirk Hill	Court				1000		21228				•
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Marical Examiner must be notified at	Completed by Funeral				edent Ever in U	10 12	Was Doordont	of Hispan	ic Origin? (Sp	ecity Yes or No		S.A.	merican Indian,
	er de	Š	11. Marital Status	ord Married	Armed Fo	rces?	7.5.	If Yes, specify (Cuban, Me	exican, Puerto	Rican, etc.)			/hite, etc.
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21215-0036	hour	8		Decedent's E			16a Dece	dent's Usual Oc	connation			16b K	ind of Busine	es/Industry
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12	withii ane. than	ᇤ	Elementary/Secondary	y (0-12)	College (1	-4or 5+)								
7	fygie ther nt, u	ပိ	17. Father's Name (First,	Middle Last	2		Reg	istered			e (First, Middle		[ealth	Care
Ĭ,	be f battal h d ol	Be												
2	oufd Mer Mark	၉	George Jose								izabeth			7- O-4-1
Maryland	2 sh and is n		19a. Informant's Name/F		**			•			al Route Numb			e, <i>zip</i> Code)
4	and ealth m 27		Paul J. Gro		- Son	ant	1				ille, M			Town Chate
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Madical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cre		Removal from		cemetery, cre	osition (Name o matory or other	place)		Date	20c. Lo	ocation - City	or Town, State
Ē	Pag ment ant: ury c		4 □Donation 5 □				ly Cro	ss Ceme	etery	2/22	/2006	G1e	n Burr	nie, MD
alt	permit. Departimport any inj		21. Signature of Funeral	Service Lice	isee /		/_ 	2. Name and Ad	ddress of	Facility Ste	f 630 E	Ashto	on-Sch dson A	wab-Witzke ve.
m	89 = 29		Deme	and,	Calla	odole		atonsvi						
			23a. Part1. Enter the dis shock, or heart fail	sease, or con	plications that c	aused the dea						rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	-	0110 04400 011 0	V		`						Onset and Death
	/Medical		disease or condition resulting in death)	-	a	or as a conse	MONI	1						
	Examiner			- 1	0	MEST		HEART	Ex	ALLIRE				
		e	Sequentially list condition if any, leading to immed	ons, liate		or as a conse		JOHN		TICON				
	t sit	듄	if any, leading to immed cause. Enter Underlying Cause (Disease or injury	1	C	arresa	101	PRIEN	V	Disc	EASE	,		
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8760,	cate be executed physician and the burial-transit	dical Examiner		l	d									
89	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				u									
	that the death certificated by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pred	anant .	23c. If yes, out								23d. Date of	delivery
Вох	atter for u	clar	in the past 12 mont	ths?		irth 2 Fet		□Ectopic pregna □ Other (specify					Month	Day Year
Ö	he d the ched	ysl	1 ☐ Yes 2 🗖 No 9 ☐ Unknown		9□ Unkn			,						
P.0	that t	P.	Part II. Dther significant	t conditions	contributing to de	eath but not re	sulting in the u	nderlying cause	e given in	Part I.	23e. Did	tobacco	use contribut	e to the cause of death?
ds,	w requires that s been signed E s should be deta	d b	DIABET	E C Y	MELLIT	WS.					1 🗆	Yes 2	© No 3 □	Probably 4 Unknown
Ö	requ	ete		<u> </u>							04-146-	/	0.45 144	
Records,	sician: The law scertificate has b irector, page 2 s	Completed by	-								24a. Was		prior deatl	e autopsy findings available to completion of cause of h?
F		Ö									1□ Yes	21X No		
Vital	cian ertifi ector	Be	25. Was case referred to examiner?	o medical	1 le emitedo					Place of Deat	th (Check only	one)		
of	> .9 0	2	1 ☐ Yes 2 No				ER/Outpatie			Nursing Ho	ome 5 Res			Specify)
П	ding P	on:	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe	now inju	ry occurred	
Si	endi eath. or: A	catl	2 Accident	investigatio				М	1 TYes	2 🗆 No				
Division	r Att	ţį.	3 ☐ Suicide 6 [4 ☐ Homicide	determined	280. Place	of Injury - At h ng, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory, off	fice		City or To			r Rural Route Number,
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification:			nysician: To the minar: On the b									r as stated. due to the cause(s)
	the Hin 24 the Fiplete	edi	one)			ner stated.								
L	Vith To	2	29b. Signature and title	of certifier 0	15 m	tam.	0	29c. Lie	cense nu					Ionth, Day, Year)
	<		Sportin	-U VI		~-! 111		1	7 41	410		1-2h	ruary	17, 1 700 P
1	D		30. Name and address of	of person who	completed caus	e of death (Ite	m 23a) (Type	Print) 100	GINC	SER P	MEHT	TA		
1	V		MATTANK	EST H	OSPITAL	LEN	ITER	RAND			MO	2	11 33	,
	Sta		31. Date filed (Month, D.		32. R	egistrar's Sign	nature						-	
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DHMH 17 Rev 1/2001

ORIGINAL

AEM 06-01121 Gravis Clark Gibbs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

'1S	Clark	Gli	DDS 1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate				giene Reg. No.	06	04999
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath	Year	3. Time of Death
	Physici /Medio			Garvi	s Clark Gi	bbs			Februa	ry 12,	2006	11:55 P [™]
}	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	own, or Loca	ation of Death			ity of Death	
1			4102 Edgehill Aver			1		e City		n/a		
	Funeral		5. Social Security Number 6. Security Number 1216–84–2515	x 7. Ag gm 2□F	e (In yrs. last birthday) Ο Ι. Yrs.	If Under 1 Months I		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da	y, Year)	Coun	
	Director		Usual Residence of Decedent		34 Yrs.				Jan. 4,	1972	Mary	land
	yland		10a. State 10b. County		10c. City, Town or Le	ocation					11	0d. Inside City Limits
	Mar	ţċ	Maryland N/A			Balti	more					XXYes 2 □ No
	th the	lre	10e. Street and Number			10f. Zip C				10g. Citizen o		try?
	23a	ral	4137 Falls Road				212				USA	
	er de	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		Was Deceder If Yes, specify	nt of Hispan Cuban, Me	nic Origin? (Spe lexican, Puerto	ecify Yes or No- Rican, etc.)	14. A	ace - Americ lack, White, o	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XXDivorced	1 ☐ Yes 2 7 3 If Yes, Give Year or Dates:	40	1 □ Yes 2 4 □	X No Sp	pecify:		Spec	eify: W	hite
9	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f ehow disal Examinat musi be notified at	Completed by	15. Decedent's Ed	ucation	16a. Dece	dent's Usual (Occupation			16b. Kind of	Business/Inc	lustry
215	hin 72	pie	(Specify only highest grade Elementary/Secondary (0-12)	de completed) Coflege (1-4or 5	i+i			g most of work	ng			
21	giene giene	Son	9		Co	nstruc						uction
nd	d oth	Be	17. Father's Name (First, Middle, Last) Victor R. Gibbs, S	· m			18.		(First, Middle, E. A11		am <i>e)</i>	
Z	Men Men Merke Metic	To			400 14-70		2. 30				- 0 7:-	Codel
Maryland 21215-0036	12 st h and 7 is n traun		19a. Informant's Name/Relationship (7) Louise E. Adelsbe			-			<i>l Route Numbe</i> timore,			1211
ė, –	1 and Healt em 2		20a. Method of Disposition	igei noti	20b. Place of Dispo	sition (Name	of		ate	20c. Location		
no	ages ant of it; if if		1 ☐ Burial 2 ☐ Wemation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metro Cr			2/16/	2006	Catons	ville.	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f ehow way injury or other traumatic event, the Mudical Examinat must be notified at ance.		21. Signature of Funeral Service Licens		2.	Name and	Address of	Facility				
ä	Depar Impo any ir		Land Con	Denta	$- \begin{vmatrix} B \\ 3 \end{vmatrix}$	urgee-l 631 Fai	Henss 11s Ro	-Seitz oad Ba	Funeral 1timore	Home, Marv	Inc. land	21211
			23a- Part1. Enter the disease, or comp shock, or heart failure. List only	cations that caused he cause on each lin	the death. Do not en	ter the mode of	of dying, su	ich as cardiac d	or respiratory ar	rest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	2		JGIN						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	Examiner	_	Sequentially list conditions,	b. Due to (or as	a consequence of):							
V	nsit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (5) 43	a 50.150qab1100 01).							
·,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Exai	that initiated events resulting in death) Last	c Due to (or as	a consequence of):							
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9	rtifical ng ph as th	Λedi	AL PERMANE.				· <u>-</u>				1	
Вох	eath certific attending pl	an/h	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth		∃Ectopic preg	nancy			3	Date of delive	ry Day Year
	e dea the at ned fo	Physician/Me	t Yes 2 No	4□Pregnant at 9□Unknown	time of death 5	Other (spec	ify)			, "	701111	Duy . Ga.
P.O.	that the de ned by the a detached t		Part fl. Other significant conditions co	ontobuting to death b	ut not resulting in the u	nderlying cau	se given in	Part I	23e. Did to	obacco use co	ntribute to th	e cause of death?
Records,	signed d be del	d by			•	, ,			101	res 2 Dio	3 🗌 Prob	ably 4 □Unknown
Ö	w require been si should I	ete							24a. Was	an 24k	. Were auto	osy findings available
Re	o = o	Completed							autop	rmed?	prior to condeath?	osy findings available inpletion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26.	Place of Death	(Check only o		15005	2010
of Vital	Physician: r this certific ral director,	To B	examiner? XXXes 2 □ No	Hospital:	int 2 ER/Outpatier	nt 3□ DOA	Other: 4	☐ Nursing Ho	me 5□ Resid	tence XXX	ther (Specify	Scene
	ding Pt J. After th funeral		27. Manner of Death 1 □ Naturaí 5 □ Pending	28a. Date of fnjur (Month, Day	y Year) 28b. Time o	28c	. Injury at Work?	1/				
Division	Attending or death. octor: Alter by the fune	Certification:	2 Accident investigation 3 Duicide 6 Could not be	2/12/06	2355	М	1 🗌 Yes	/\				
Ξ	or At	rtiff	4 Homicide determined	building, etc	ury - At home, farm, str c. (Specify)	eet, factory, c	office		City or Tow	vn, State)		PRoute Number,
	spitai ours s nerai I		29a. Certifier 1 ☐ Certifying Phy		ARA4.£ of my knowledge, deat	n occurred at	the time. da	ate and place	and due to the	SACTI cause(s) and	manner as st	ated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai			examination and/or in							
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. L	icense num	mber		29d. Date sign	ned (Month, i	Day, Year)
			· /	/(/	~		OCME		1	Februar	y 13,	2006
	3		30. Name and address of person who c	ompleted cause of d	eath (ftem 23a) (Type,		D	CL	D-1.	nore 1	formal	ad 21201
			31. Date filed (Month, Day, Year)	32 Rosser	ar's Signature	111	renn	street	, baiti	nore, N	агута	nd 21201
	Sta Registr		FEB 2 1	2006	A	hearth 1	,					

State of Maryland / Department of Health and Mental Hygiene 05000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** February 16, 2006 4:30 Jack Anthony Greenwald /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Manor Care Health Services Rossville Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Oct. 8, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1XXM 2□ F Yrs. 83 109-22-8759 Hungary Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov 1 ☐ Yes 🏋 No Baltimore Maryland Baltimore Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, tra Medical Examiner must be 7106 Gough Street 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 XX es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2KXMarried ارس المرس المرس المرس المرس المرس المرس Baltimore, Maryland 21215-0020 WWII 1 ☐ Yes XX No Specify: Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State Of Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Greenwald Helen Hoskie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7106 Gough Street Baltimore County, Maryland 21224 Aileen Greenwald (Wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XDBuriel 2 ☐ Cremetion 3 ☐ Removal from State Gardens Of Faith Cemetery2/20/2006 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fullity
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a: Part1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, theart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Imm. te Cause (Final disease or condition resulting in death) /Medical DAY> · INTNACENERAL Examiner Due to (or as a consequence of) by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: After this cartificate has been signed by the attending physician and filled in by the funeral diractor, page 2 should be datached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SEASIS 24b. Were autopsy findings 24a. Was an autopsy performed? Completed aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) n いつghi WD EBRUARY 17 2006 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) OSCEN TOWSON UMD uns 7505 DUIVE 31. Date filed (Month, Day, Year) 32. Pygistrer's Signeture State FEB 2 1 2006 Registrar

Greenwald